





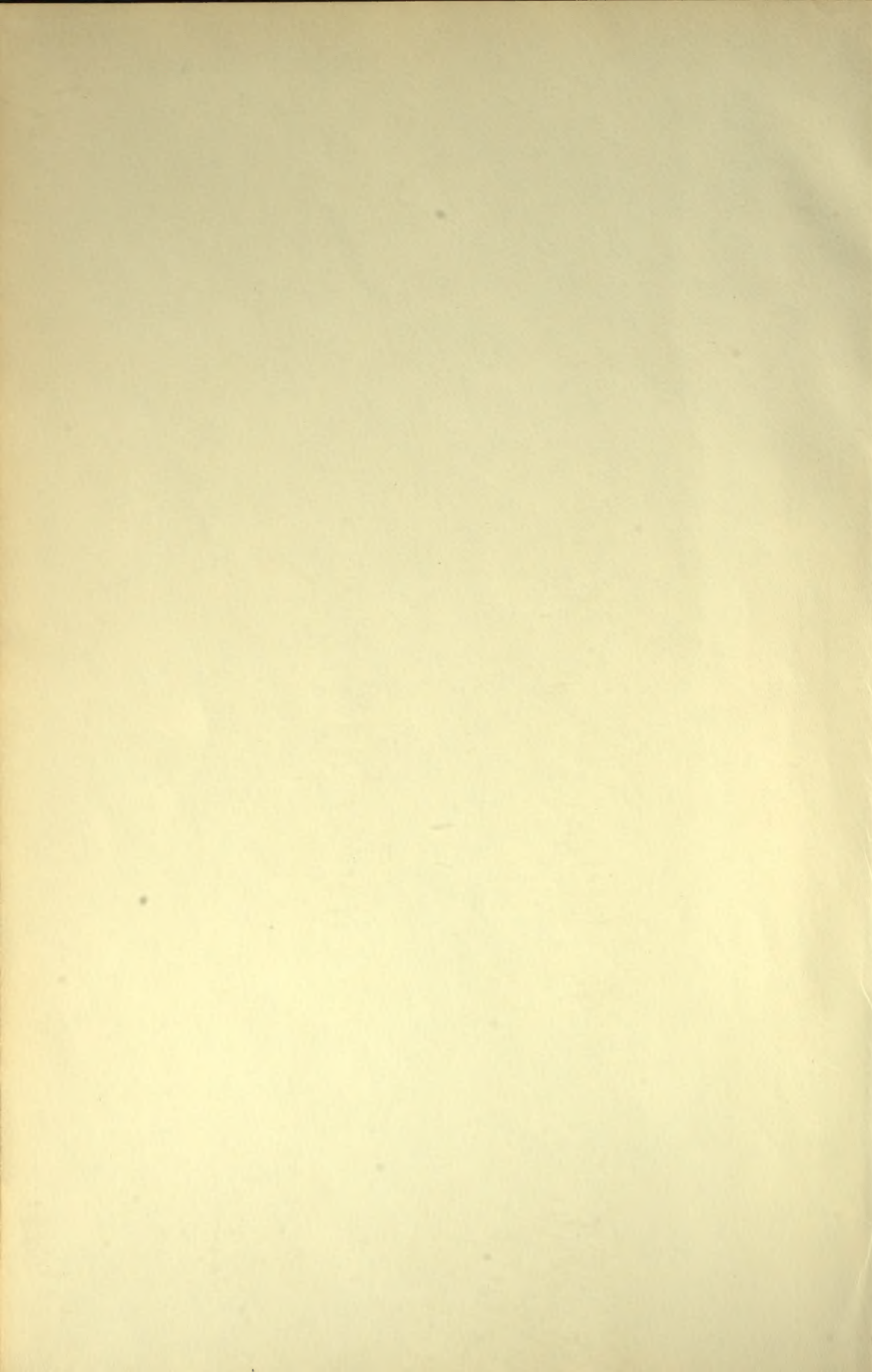


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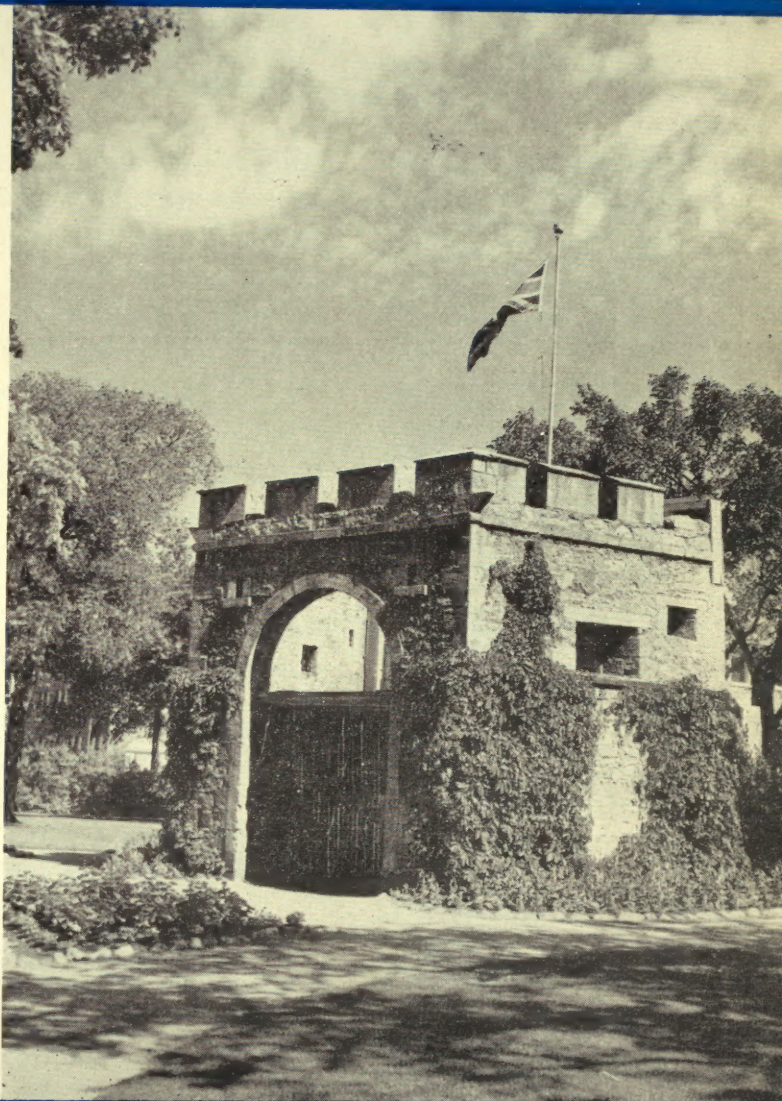


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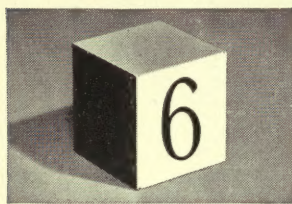
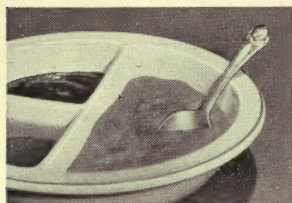
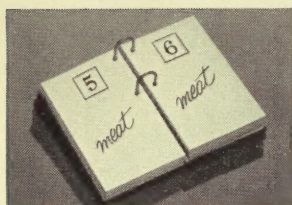
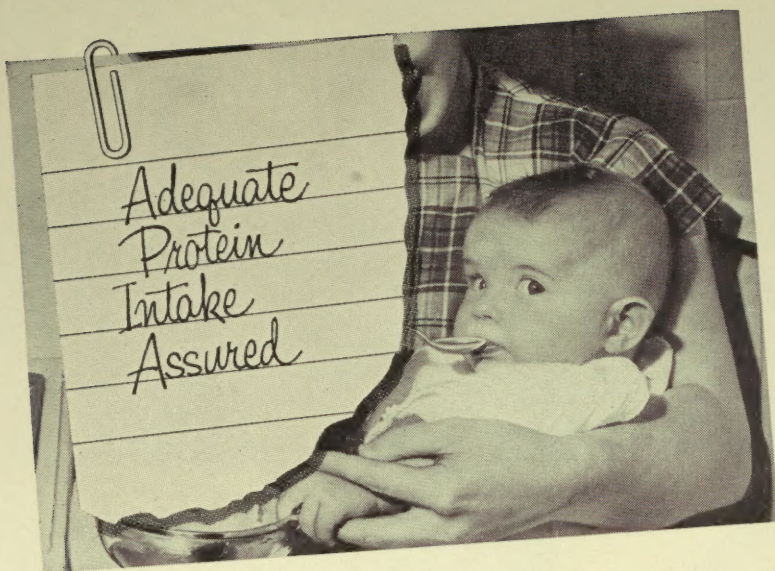
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INDEX

Volume 52

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# THE CANADIAN NURSE

## Index to Volume 52

### January — December 1956

The material in this Index is arranged under subjects, authors, and titles. Titles are given in full with the author's name.

The following abbreviations appear in this Index:

- CNA — Canadian Nurses' Association  
(ed.) — editorial  
I.C.N. — International Council of Nurses  
(por.) — portrait  
(rev.) — book review

The page numbers for Volume 52 are shown below:

January .....	pp. 1- 80	July .....	pp. 505 - 584
February .....	pp. 81-160	August .....	pp. 585 - 672
March .....	pp. 161-240	September .....	pp. 673 - 768
April .....	pp. 241-320	October .....	pp. 769 - 856
May .....	pp. 321-408	November .....	pp. 857 - 936
June .....	pp. 409-504	December .....	pp. 937-1024

#### A

ACCIDENT prevention:  
Role of the industrial nurse in (Greville), 112

ACCREDITATION and evaluation, 280, 695

Let's look at, 368

Où en sommes-nous (McQuarrie), 444

Pilot study, 736

Resolutions regarding, 697

What's on the record (McQuarrie), 443

ACCREDITATION — où en sommes-nous (McQuarrie), 444

ACCREDITATION — what's on the record (McQuarrie), 443

ADVENTURES in science teaching (Alderson), 271

AIDS to surgical nursing (Armstrong), (rev.), 990

ALBERTA:

Medicine Hat General Hospital, 980

News notes, 62, 144, 224, 299, 389, 472, 557, 649, 752, 992

Provincial association activities, 441

Student nurses' association of, 212

ALDERSON, Henrietta J.

Adventures in science teaching, 271

ALDRICH, C. Anderson (Aldrich)

*Babies are human beings* (rev.), 216

ALDRICH, Mary M. (Aldrich)

*Babies are human beings* (rev.), 216

ALLEN, Moyra

Venture in field experience for graduate nurses, 276

AND the world too (McArthur), 703

ANDERSON, Bernice E. (Lesnik)

*Nursing practice and the law* (rev.), 556

ANDERSON, Florence M. (rev.), 56

ANNUAL meetings:

New Brunswick (Archibald), 130

Prince Edward Island (Bolger), 50, 984

Saskatchewan (Wilson), 898

APPLETON, Joan & por., 839

ARCHIBALD, Muriel

Annual meeting in New Brunswick, 130

ARE we equal to our future (Sanders), (ed.), 781

ARMSTRONG, Katherine F.

*Aids to surgical nursing* (rev.), 990

ARNSTEIN, Margaret G. & por., 214, 693

Improving nursing service, 869

ARRANGEMENTS committee, report of, 288

ARTHRITIS and rheumatism:

Rheumatoid arthritis (Ziehran), 448

ATTITUDES in psychiatric nursing care (Weiss), (rev.), 385

AUXILIARY nursing:

Orderly training program (Richmond), 191

AVERY, Mavis L., 368, 458

#### B

BABIES are human beings (Aldrich, Aldrich), (rev.), 216

BAILEY, Hamilton

*Demonstrations of operative surgery* (rev.), 218

BAKER, Jean (rev.), 216

BANDL's ring (Foster, McLeod, Palframan, Shouldice), 266

BANGHAM, Mary Dickerson

A thought for spring (poem), 256

BARKER, Gladys

Dish-washing center, 380

- BELL, Daphne  
When a nurse has diabetes, 627
- BELL, Louise Price  
Counterpane land, 107  
K.P. for double-duty homemakers, 884
- BENTLEY, T. J., 689  
Saskatchewan's expanding health services, 699
- BESOINS de l'écolier en matière de santé (Ranger), 52
- BIENNIAL convention, 1956:  
Are we equal to our future (Sanders), (ed.), 781  
Fun on trains (Steed), 185  
Mrs. Toohey at the booth (por.), 691  
Official notice (Stiver), 356  
Registration reaches new high, 734  
Report of the arrangements committee, 288  
Sommes-nous en mesure de faire face à l'avenir (Sanders), (ed.), 785  
Tentative program for, 284  
What about vacation plans (Collins), 109  
Why attend the CNA, (Carmel), (ed.), 255
- BIETSCH, Elizabeth  
Graduation pictures, 980
- BIFOCAL approach (Sinclair), 880
- BIRTH of industrial nursing (Charley), (rev.), 218
- BIXLER, Genevieve K., 550
- BLACK, J. (Skerry, MacLean, Kennedy, MacDonald)  
Radioactive isotopes, 800
- BLACKWOOD, M. (rev.), 290
- BLAKE, Florence G. (Jeans, Wright)  
*Essentials of pediatrics* (rev.), 218
- BLOOD conditions:  
Chromosome deletion in the Rh genotype (Graves), 18  
Leukemia (Schweisheimer), 724  
Quelques considérations sur l'anémie et les états anémiques (Tessier), 728
- BLOOD pressure:  
Hypotension (Schweisheimer), 53
- BOLGER, Helen L.  
Annual meeting in Prince Edward Island, 50, 984
- BOYD, Annie Black & por., 543
- BRAGDON, Jane Sherburn (Emerson)  
*Essentials of medicine* (rev.), 56
- BRAGDON, Jane Sherburn (Sholtis)  
*Teaching medical and surgical nursing* (rev.), 56
- BRANDON, Katherine, 46, 62
- BRANION, O., 563
- BREATH of pain (Bromage), 45
- BREGG, Elizabeth  
Psychiatric nursing, 183
- BRIDGES, Daisy, 548
- BRIEFS:  
to Royal Commission on the economic future of Canada, 366, 548, 690
- BRITISH Columbia:  
News notes, 63, 149, 225, 299, 389, 473, 559, 650, 753, 838, 920, 994  
Provincial association activities, 441  
Public health nursing service: appointments, transfers, resignations, 296, 915
- BROMAGE, P. R.  
Breath of pain, 45
- BROOKS, E. L. (rev.), 747
- BROWN, Esther Lucille  
Social sciences and improvement of patient care, 175
- BROWN, Esther Lucille (Greenblatt, York)  
*From custodial to therapeutic patient care in mental hospitals* (rev.), 912
- BROWNE, O'Donel  
*Rotunda textbook of midwifery for nurses* (rev.), 54
- BRYCE, Margaret  
*Physical therapy after amputation, the treatment of the unilateral lower extremity amputee*, (rev.), 385
- BULLOCK, Joyce (Wright)  
Meconium ileus, 193
- BURNS:  
Salles pour enfants brûlés (Tanner), 383
- BUTLER, Ethelyn  
From little acorns, 31
- C**
- CAIRNEY, John  
*Gynecology for senior students of nursing* (rev.), 216
- CALVE, Carmen  
L'infirmière en obstétrique, 742
- CAMERON, Charles S.  
*Truth about cancer* (rev.), 990
- CAMPBELL, D. L., 687
- CAMPION, F. Lillian, 822  
Orientation, 447  
Toward better nursing, 693
- CAMPKIN, Joyce B. (rev.), 56
- CANADIAN Nurse award, 648, 860
- CANADIAN Nurses' Association:  
Brief to the Royal Commission, 366, 548, 690  
Committee manual, 981  
National committee chairmen, 822  
Nurses: their education and their role in health programs, 347, 696, 791  
Ticket of nominations, 376  
Yearbook of modern nursing, contribution to, 548
- CANADIAN Red Cross Society:  
Appointments, transfers, resignations, 60
- CANCER:  
Epidermoid carcinoma (Watanabe), 534  
Leukemia (Schweisheimer), 724  
Service social et le cancer (Chamard), 268
- CAPLAN, Hyman (Dimock)  
Student nurse in a pediatric setting, 959
- CARMEL, Sister Theresa (por.), 255  
Why attend the CNA convention, (ed.), 255
- CARPENTER, Helen M. & por., 804  
Legislation and bylaws, 691
- CARTER, G. B.  
Some considerations on the basic nursing curriculum, 357
- CAVELL, Cynthia, 38
- CAVERNOUS sinus thrombosis (Lawton, Hobin), 120
- CECELIA, Sister Mary Ann  
Child with laryngotracheo bronchitis, 351
- CHAMARD, Ghislaine  
Service social et le cancer, 268
- CHANGE of address information, 676
- CHANGING attitudes (Phillips), 708
- CHAPTER meetings, ideas for, 898



- CHARLEY, Irene H.  
*Birth of industrial nursing* (rev.), 218  
 CHILD in hospital (Faughnan), 956  
 CHILD with laryngotracheo bronchitis (Cecelia), 351  
 CHITTICK, Rae, 695  
 CHROMOSOME deletion in the Rh genotype (Graves), 18  
 CHRISTMAS in Korea (McArthur), (ed.), 949  
 CIRCULATORY system:  
   For the man of the future, 836  
 CIVIL defence:  
   In time of need (MacGregor), 517  
   Integration of, nursing into the basic curriculum, 47  
   Nurses' role in, 186  
   Panel discussion at biennial, 696  
   Preparation for natural disasters, 454  
 CLARK, Jeanie S. (rev.), 140  
 CLARKE, Fred  
   Life, profession and school, 530, 640, 715  
 COCKAYNE, Elizabeth, 790  
 COHEN, Fay (rev.), 384  
 COLLINS, Ethel Armstrong  
   What about vacation plans, 109  
 COLUMKILLE, Sister, 474  
 COMMON sense safety precautions, 714  
 COMMUNICABLE diseases:  
   Scarlatine plus endomyocardite (Payer), 891  
   Staphylococcal pneumonia (Demko), 971  
 CONFUSING notions of mental health (Stokes), 519  
 CONSEILS à une étudiante devant faire un stage à la salle d'opération (Lupien), 832  
 CONVENTION personalities:  
   Arnstein, Margaret G., 214  
   Sanders, Byrne Hope, 350  
   Schwier, Mildred E., 438  
   Sinclair, Adelaide, 214  
 COTE, Lucille & por., 38  
 COUNTERPANE land (Bell), 107  
 COX, Dorothy & por., 199  
 CRAWFORD, Annie Laurie (Kilander)  
   *Nursing manual for psychiatric aides* (rev.), 468  
 CREATIVE nursing (Schwier), 875  
 CROLL, Marie C.  
   A women's auxiliary in action, 25  
 CROUSE, Vivian  
   Infirmières des salles d'opération, 198  
   Operating room nurses, 198  
 CROW, A. (Crow, Skinner)  
   *Psychology in nursing practice* (rev.), 466  
 CROW, L. (Crow, Skinner)  
   *Psychology in nursing practice* (rev.), 466  
 CRUICKSHANK, W. H.  
   Mental health for nurses, 95  
 CUMMINS, Jean A. (rev.), 218  
 CURRICULUM:  
   Direction in regard to, 126  
   Some considerations on the basic nursing, (Carter), 357  
 CURRICULUM study in basic nursing education (Sand), (rev.), 219
- DAVID, Paul  
 L'évolution de la cardiologie et ses problèmes, 21, 101  
 DE LA SAGESSE, Soeur Valerie & por., 978  
 DE LOYOLA, Sister Mary & por., 543  
 DE MONTFORT, Soeur Noëmi & por., 977  
 DE SALES, Sister Mary Frances, 805  
 DEMKO, Clara  
   Staphylococcal pneumonia, 971  
 DEMONSTRATIONS of operative surgery (Bailey), (rev.), 218  
 DENTAL hygiene:  
   Fluoridation, 179  
 DERSCO, Mary  
   Diabetes mellitus, 617  
 DESJARDINS, P., 475  
 DIABETES:  
   Diabetes mellitus (Dersco), 617  
   When a nurse has diabetes (Bell), 627  
 DIABETES mellitus (Dersco), 617  
 DICK, Dorothy (rev.), 288  
 DIMOCK, Hedley G.  
   Process notes on the work conference, 951  
 DIMOCK, Hedley G. (Caplan)  
   Student nurse in a pediatric setting, 959  
 DION, Soeur Annette  
   Expérimentation dans le domaine de l'éducation de l'infirmière, 445  
 DISC lesions:  
   Management of lumbar intervertebral (Rosen), 423  
   Nursing care of patients with lumbar intervertebral, (MacTavish, MacQuarrie), 429  
 DISH-WASHING center (Barker), 380  
 DISTRICT nurse knows better (Kirk), 180  
 DIXON, Nancy, 550  
 DODKIN, R. (Richards)  
   Salt-losing nephritis, 537  
 DORIS, Sister Mary  
   Glomerulonephritis, 712  
 DRUGS:  
   Achrocin tablets, 943; Actylasec, 414; Albamycin capsules, 774; Alma C, 6; Ambar, 6; Amyotensin, 512; Analeptone, elixir, 328; Anatensin forte, 680; Antrenyl, 512; Azo-gantrisin, 680  
   Bactisubtil, 943; Barbided, 942; Bionet drops, 166; Bonadoxin, 774; Bonamine tablets, 680; Bontril, 6; Bronchyl D, 414; Butiserpine, 328; Butisol, 166  
   Calcitrine syrup with codeine, 942; Candettes, 328; Centrine injection, 590; Cerevon tablets, elixir, 510; Colace, 590; Colforos, 246; Colisal-H, 328; Colisone, 166; Colisyl plain, 942; Combistrep 774; Constiban, 680; Convenil, 510; Cordex tablets, 774; Coricidin forte capsules, 590; Coroserp, 246; Cytoferin, 590  
   Debiline-homatrophine, 942; Deltra tablets, 6; Denabyl, 942; Dexavite, 680; Dextohist, 510; Diacitrin, 414; Diaparene lotion, 246; Dicosal, 166; Dicurin procan solution, 328; Dilanca, 414; Dithritol, 774; Dolorub, 246; Drapolene, 590  
   Ebsophyllin-R, 6; Encote A.S.A., 6; Enterobiotic tablets, 246; Equanal, 246  
   Falgos, 942; Fiorinal, 330; Fleet enema, 774; Flexin, 590; Frenquel hydrochloride, 88
- D
- DALTON, Ann  
 My complaints, 197

Gamadyne No. 1, No. 2, No. 3, 166;  
Gamatuss, 166; Gelusil-lac, 414; Gold  
sodium thiosulphate, 166; Graval long  
acting, 591  
Hemo coavit, 330; Hexaphenyl, 88;  
Honvol, 414; Hydro dyne, 942; Hyptrol  
spansule, 863; Hylenta tablets, 168  
Ibacide cream, 776; I.D.M., 510; Influenza  
virus vaccine polyvalent, 168  
Juvalin, 330  
K-C tablets, 88  
Ledercillin tablets, 943; Liquid sobee, 168  
Medihaler-epi, 776; Medomin, 510; Mega-  
cillin drops, 863; Mephenesin, 510;  
Meratran with reserpine, 511; Mestinin,  
510; Meticortelone acetate, 592; Meti-  
derm with neomycin ointment, 680;  
Migraine tablets, 86; Mycostatin oint-  
ment, 415  
Nembu-serpin, 86; Neo-barb dures tablets,  
678; Neo-cortef lotion 1%, 591; Neo-  
tensol, 331; Neuro-centrine tablets, 88;  
Neutra detergent cake, 168; Neutratar  
shampoo, 168  
Pabalate-HC, 168; Pacatal, 678; Parasal-  
S.A.  $\bar{c}$  INH, 678; Parenzymol, 415;  
Paynocil, 511; Pectorea, 168; Persistin,  
678; Placidyl, 86; (PR) corsalent, 680;  
Protost in oil, 6; Protovab, 776  
Relissen, 415; Rhulispray, 863; Ritalin,  
246  
Sabol, 590; Sedrate, 6; Sedwell, 88;  
Seromycin crystalline, 862; Seipatilin,  
776; Sertens, 678; Sigmagen, 330;  
Sparine, 678; Statimo, 86; Strepto-  
hydrazid, 862; Stytron, 862; Sulfacet  
suspension, 862; Sustagen, 416; Suvren,  
776  
Tarcortin cream, 331; Tes-tape, 862;  
Tetracyc-SF, 416; Thiosulfil solution,  
415; Thyama timesules, 168; Tolerin,  
591; Tolox expectorant, 512; Tranplex,  
416; Trawil capsule, 88; Tridal, 591;  
Triethylene melamine tablets, 248;  
Tronolen lotion, 511; Trulfacillin tab-  
lets, 862; Trypsogen, 88; Tylandril,  
864; Tyzine nasal spray, 416  
Urosulfa, 248  
Valmid, 86; V-Cillin, 328; Veratrite-R,  
414; Voyagol, 511  
Xylocaine viscous, 86  
Zyljectin ampoules, 776

## E

### EDITORIALS:

Are we equal to our future (Sanders), 781  
Christmas in Korea (McArthur), 949  
Forty years of pilgrimage (Russell), 173  
In time of need (MacGregor), 517  
Our senior citizens (Wilson), 421  
Prairie convention, 687  
Salaam aliakum (Sharpe), 13  
Service, responsibility, nurture, action  
(MacKenzie), 337  
Sommes-nous en mesure de faire face à  
l'avenir (Sanders), 785  
Tomorrow's pattern (Sharpe), 597  
Too few for too many (Girard), 93  
Why attend the CNA convention  
(Carmel), 255

### ELECTROLYTES:

Fluid balance (Partington), 262  
ELIASON, E. L. (Ferguson, Sholtis)  
*Surgical nursing* (rev.), 56  
EMERSON, Charles Phillips (Bragdon)  
*Essentials of medicine* (rev.), 56  
ENFANT est né trop tôt (Saint-Martin), 345  
EPIDERMOID carcinoma (Watanabe), 534  
ESSENTIALS of medicine (Emerson, Brag-  
don), (rev.), 56  
ESSENTIALS of pediatrics (Jeans, Wright,  
Blake), (rev.), 218  
ETHICAL religious needs of the patient  
(Frumkin), 263  
EVANS, Ruth E.  
Greenhorn on the frontier, 974  
EVOLUTION de la cardiologie et ses problèmes  
(David), 21, 101  
EXPERIMENTATION dans le domaine de l'édu-  
cation de l'infirmière (Dion), 445

## F

FALLIS, Anne (rev.), 990  
FATIGUE factor in peptic ulcers, 223  
FAUGHNAN, Jeanne E.  
Child in hospital, 956  
FEELY, Irene (rev.), 136  
FELICITAS, Sister M. & por., 805  
Institute on communications, 346  
FERGUSON, J. Frances & por., 199  
FERGUSON, L. K. (Eliason, Sholtis)  
*Surgical nursing* (rev.), 56  
FERGUSON, T. (MacPhail)  
*Hospital and community* (rev.), 458  
FIDLER, Gail S. (Fidler)  
*Introduction to psychiatric occupational  
therapy* (rev.), 746  
FIDLER, J. W. (Fidler)  
*Introduction to psychiatric occupational  
therapy* (rev.), 746  
FIELDWORK experience:  
Venture in, for graduate nurses (Allen),  
276  
FILMS:  
Rehabilitation, 824  
FISCHER-WILLIAMS, M.  
*Management of acute poliomyelitis* (rev.),  
290  
FLANDER, Madeleine  
Pediatric work conference, 951  
Some thoughtful conclusions, 966  
FLITTER, Hessel H. (Rowe)  
*Teaching physiology and anatomy in  
nursing* (rev.), 138  
FLORENCE Nightingale International Founda-  
tion:  
Planning of nursing studies, 822  
FLUID balance (Partington), 262  
FLUORIDATION, 179  
FOOT health:  
Scientists probe, 749  
FOREIGN countries:  
Korea —  
And the world too (McArthur), 703  
Christmas in (McArthur), 949  
Turkey —  
Salaam aliakum (Sharpe), 13  
FORTY years of pilgrimage (Russell), (ed.),  
173



FOSTER, P. (McLeod, Palframan, Shouldice)  
 Band's ring, 266  
 FROM *custodial to therapeutic patient care in mental hospitals*  
 (Greenblatt, York, Brown), (rev.), 912  
 FROM little acorns (Butler), 31  
 FRUMESS, Gerald M.  
 Skin, mirror of emotions, 374  
 FRUMKIN, Robert M.  
 Ethical religious needs of the patient, 263  
 FUN on trains (Steed), 185  
 FUTURE nurses' club, 533

G

GALDSTON, Iago  
 Meaning of social medicine (rev.), 290  
 GASTROINTESTINAL conditions:  
 Fatigue factor in peptic ulcers, 223  
 GAZAWAY, Rena (Hayes)  
 Human relations in nursing (rev.), 288  
 GENERAL staff nursing:  
 K.P. for double-duty homemakers (Bell), 884  
 GERIATRICS:  
 Changing attitudes (Phillips), 708  
 Impact of chronic illness (Phillips), 524  
 Meaning of rehabilitation (Wellard), 904  
 Our senior citizens (Wilson), 421  
 Proportion of aged in population, 975  
 Role of the nurse in rehabilitation (Phillips), 810  
 What it means to be old (Phillips), 611  
 GERMAIN, Guy  
 Importance de dosage ingéré et excrété, 462  
 GIRARD, Alice (por.), 84, 93, 693 (& por.), 804  
 Too few for too many (ed.), 93  
 GIROUX, Suzanne  
 Soins des enfants, 968  
 GLOMERULONEPHRITIS (Doris), 712  
 GOOSTRAY, Stella (Schwenck)  
 Textbook of chemistry (rev.), 468  
 GOULDING, Fern A. (Torrop)  
 Practical nurse and her patient (rev.), 748  
 GRADUATION pictures (Bietsch), 980  
 GRAHAM, Muriel Jean & por., 544  
 GRAHAM, Pearl (rev.), 136  
 GRAVES, Gilda G.  
 Chromosome deletion in the Rh genotype, 18  
 GREENBLATT, Milton (York, Brown)  
 From custodial to therapeutic patient care in mental hospitals (rev.), 912  
 GREENHORN on the frontier (Evans), 974  
 GREISHEIMER, Esther M.  
 Physiology and anatomy (rev.), 138  
 GREVILLE, Theresa (rev.), 218  
 Role of the industrial nurse in accident prevention, 112  
 GRENEWALD, Emily (rev.), 748  
 With our training we can help, 122  
 GROWTH and development of infants:  
 Development at various ages, 834  
 From little acorns (Butler), 31  
 GYNECOLOGY for senior students of nursing (Cairney), (rev.), 216

H

HALL, Gertrude M. (rev.), 913  
 HALLAM, Ruth (rev.), 56  
 HAMILTON, James A.  
 University education for administration in hospitals (rev.), 54  
 HAYES, Wayland J. (Gazaway)  
 Human relations in nursing (rev.), 288  
 HEALTH insurance:  
 New publications, 824  
 HEART conditions:  
 L'évolution de la cardiologie et ses problèmes (David), 21, 101  
 Scarlatine plus endomyocardite (Payer), 891  
 HEART disease nursing — Teachers College, Columbia University, 442  
 HISTORIC Manitoba, 339  
 HISTORICAL:  
 In the good old days (*The Canadian Nurse*), 42, 106, 220, 294, 387, 469, 554, 646, 711, 835, 874, 973  
 HOBIN, M. (Lawton)  
 Cavernous sinus thrombosis, 120  
 HOLLISTER, Dorothy G. & por., 978  
 HOME care:  
 plans, 982  
 HOSPITAL adult education (Vance), (rev.), 456  
 HOSPITAL auxiliaries:  
 A women's, in action (Croll), 25  
 HOSPITAL and community (Ferguson, MacPhail), (rev.), 458  
 HOSPITAL in-service educational training program (Vance), (rev.), 456  
 HUGHES, F. N., 6, 86, 166, 246, 328, 414, 510, 590, 678, 774, 862, 942  
 HUMAN relations in nursing (Hayes, Gazaway), (rev.), 288  
 HUNTER, Trenna G., 698, & por. 799  
 HYDROCEPHALUS (Jenkinson), 885  
 HYPOTENSION (Schweisheimer), 53

I

IMPACT of chronic illness (Phillips), 524  
 IMPORTANCE de dosage ingéré et excrété (Germain), 462  
 IMPRESSIONS d'Afrique (Tremblay), 630  
 IMPROVING nursing service (Arnstein), 869  
 INFIRMIERES des salles d'opération (Crouse), 197  
 INFIRMIERE en obstétrique (Calvé), 742  
 IN memoriam:  
 Allison, Loila (Marshall), 264; Allison, Mary Gretchen, 545; Anderson, Ethel Hilda (Hennie), 978; Anderson, Gertrude Irene, 363; Armstrong, Annie, 264; Arner, Agnes, 39; Atkinson, Mary A., 806  
 Bagshaw, Esthaol T., 200; Balloch, Jean, 722; Barclay, Ethel, 363; Beach, Margaret (McCullum), 979; Beckett, Mary Caroline, 806; Bowie, Elizabeth Jane, 111; Bradley, Anne, 264; Burns, Margaret Mary, 200  
 Caldwell, Mary Helen, 806; Campbell, Florence Nightingale (Sims), 363; Clark, Edith Grace (Bishop), 111, Clermont, Cécile, 910; Coleman, Della

# INDEX TO VOLUME 52

- Jean (Witts), 722; Coleman, Eva, 452; Conway-Jones, Katherine, 363; Corbett, Elizabeth (Quinn), 722; Cormie, Jean, 111
- Dalzell, Isabel Janet, 363; Darville, Mabel, 39; Davidson, Elizabeth (Domville), 722; Dawson, Rosa (Moor), 722; Day, Barbara Cecilia, 264; de l'Immaculee, Soeur Marthe, 626; de Lorraine, Soeur Jeanne, 626; Dean, Mary Agnes, 363; Delves, Ann Elizabeth, 452; Dock, Lavinia Lloyd, 806; Dorothea, Sister Mary, 626; Douglas, Alma, 545; Dyck, Katherine, 808; Dyer, Hilda May, 545
- Eaves, Eileen, 910; Elliott, Audrey Bernice, 910, 979; Ellis, Gladys, 979; Erskine, Alice, 910
- Fabian, Sister, 39; Farrell, Kathleen G. (Trainor), 979; Farrell, Patricia (Bazanet), 111; Feeny, Effie M., 39; Forbes, Ella, 111; Forgie, Effie Helen, 808; Forrest, Annie M., 545; Forrest, Ella Maude, 979; Forsey, Blanche, 626; Fraser, Annie (Smith), 808; Fretz, May Elizabeth, 200
- Gaassenbeek, Ruth (Kool), 910; Garrett, Mary Ann (Haire), 264; Gauthier, Doris (Trevors), 363; Gavin, Margaret Ann, 545; Glass, Robena (Williams), 452; Goldhawk, Mary, 545; Good, Bernice, 452; Gunne, Mary Graham, 39
- Hanly, Lois, 626; Hanna, Evelyn (Beatty), 264; Harrison, Christine (Musselman), 200; Hawke, Evelyn Elizabeth (Gouldie), 111; Hichens-Smith, Caroline Margaret, 722; Hill, Annie Louise (Brown), 39; Hodgins, Susan Emily, 363; Hogg, Grace Margaret, 264; Holland, Laura & por., 264; Horsnell, Cynthia Pauline, 111; Hughes, Margaret & por., 910; Humphrey, Lenore (Lyle), 626; Husband, Mary, 626; Hutchison, Ann Elizabeth, 39
- Jackson, Annie, 265; Jaques, Gwendoline, 363; Jeanne d'Arc, Sister, 265; Johnson, Jean Elizabeth (Alexander), 808
- Kesslering, Mary Jane (Bannister), 722; Kilburn, Josephine F., 201; King, Frances, 979; Kornelson, Bertha, 808
- Lagüe, Louisia, 265; Laliberté, Marie Brigitte & por., 808; Langford, Lila M., 808; Lawrence, Agnes Emily (Pederson), 364; Leckie, Jemina, 111; Legge, Caroline, 626; Le Good, Sarah Annie, 545; Liggett, Flora, 265; Lippert, Mary Carolyn (Peppler), 808; Long, Sandra Marie, 910; Lough, Laura B. (MacDermid), 910
- Macaulay, Robina, 364; MacCuaig, Florence, 39; MacDonald, Mary S., 979; MacIntosh, Daisy (Grant), 111; MacIntosh, Margaret Isobella, 979; MacNeil, Rita, 39; Mallock, Olive (Bentley), 722; Mallory, Bertha Lynetta, 546; Martin, Elizabeth Jean, 265; McCallum, Mary C (Hyde), 39; McCauley, Susanna, 979; McConnell, Florence, 722; McDermid, Margaret, 111; McDermott, Bernadette (Walsh), 111; McDonald, Florence, 722; McDonald, Rose (Kemmet), 111; McElroy, Myrtle, 265; McGugan, Gwendolyn Frances (Birt), 722; McGuire, Cecelia Eileen, 808; McIntyre, Alice (MacLeod), 724; McKeever, Grace, 545; McLaughlin, Kathleen (Grattan), 910; Miller, Mary, 626; Milligan, Frances, 265; Miserva, Elizabeth (Jones), 39; Monan, Vera (McMullin), 452; Moody, Mary Elizabeth, 546; Moore, Céline, 546; Morin, Antoinette, 201; Morrison, Barbara (Booth), 265; Morrison, Jean (Webster), 265; Morrison, Louisa, 626
- Neilly, Isabella Jane, 724; Neilson, Jean, 626; Nelson, Mary (Woods), 626
- Page, Adeline Mary, 808; Paterson, Violet (Stevens), 808; Pedlow, Margaret Elizabeth (Hunter), 111; Pinder, Ethel Patricia (Sunderland), 979; Poetschke, Helen L. (Sheldon), 546; Portland, Isobel (Robertson), 834; Probert, Lillian (Bolin), 265
- Rankine, Elva (MacKenzie), 201; Redmond, Elizabeth Mary, 201, 364; Reid, Elizabeth, 979; Rice, Flora Mary (Phillips), 201; Roberts, Mary Joyce, 910; Rose, Ethel (Boulbee), 452; Ross, Charlotte Helen, 724
- St. Bertha, Sister, 979; St. Onge, Marie-Adrienne, 364; Saunders, Ethel G., 201; Scott, Hattie May (Drake), 452; Scott, Rita Madeline (Leach), 201; Shuttleworth, Anne (Blair), 626; Sivell, Margaret, 201; Smith, B. (Collier), 546; Smith, Jean (Vallance), 626; Stanley-Jones, Lucille Laura (Ross), 111; Stevens, Mary Francis, 911; Stuart, Hilda Muir, 911
- Taylor, Mary Natalie (McAulay), 265; Townsend, Estella (Beck), 452; Traquair, Doretta Mae (Minchin), 265; Tuck, Charlotte, 834; Turnbull, Roberta Hope, 979
- Voisard, Andrée, 39
- Wade, Maud (Bennett), 626; Walker, Kathleen H., 111; Warwick, Irene (Follett), 834; Watson, Wanda (Hooper), 452; Watts, Caroline (Kennedy), 111; Webster, Clara (Evans), 724; Welbourn, Ida Clara, 452; Wharrey, Marguerite, 980; Wheeler, Mary Anne, 626; White, Genevieve, 364; Wigginton, Margaret M. (Aikman), 39; Willis, Clara (White), 201; Willis, Hilda, 265; Wiseman, Sally Ann, 626; Wyand, Caroline Agnes (Ruthven), 980
- INGRAM, Madelene Elliott  
*Principles and techniques of psychiatric nursing* (rev.), 990
- INSTITUTES:  
Administration and supervision in nursing education, 140, 550  
communications (Felicitas), 346  
Nurses' role in civil defence (Sask.), 186  
Nursing aspects in rehabilitation (Nova Scotia), 65  
Process notes on the work conference (Dimock), 951
- INSULIN therapy (Dersco), 621
- INTEGRATION of civil defence nursing into the basic curriculum, 47



# THE CANADIAN NURSE

- I.C.N. Congress — 1957, 981  
 Congress theme, 981  
 Preliminary program, 981  
 INTERNATIONAL Council of Nurses:  
 Planning of nursing studies, 822  
 Salaam aliakum (Sharpe), (ed.), 13  
 INTRODUCTION to *psychiatric occupational therapy* (Fidler, Fidler), (rev.), 746  
 In time of need (MacGregor), (ed.), 517

## J

- JAMES, Christina F.  
 Parents' point of view, 963  
 JEANS, Philip C. (Wright, Blake)  
*Essentials of pediatrics* (rev.), 218  
 JENKINSON, Joanna  
 Hydrocephalus, 885  
 JOHNSON, Ida (rev.), 220  
 JOSEPH, Sister Thomas (rev.), 385, (rev.), 990  
 JOULE, J. W.  
*Textbook of medicine for nurses* (rev.), 466

## K

- KATZ, Barney (Thorpe)  
*Understanding people in distress* (rev.), 747  
 KEEGAN, Soeur Florence (rev.), 384  
 KENNEDY, M. (Skerry, MacLean, Black, MacDonald)  
 Radioactive isotopes, 800  
 KERN, F. W., 696  
 KIDNEY conditions:  
 Glomerulonephritis (Doris), 712  
 Salt-losing nephritis (Richards, Dodkin), 537  
 KILANDER, Virginia Curry (Crawford)  
*Nursing manual for psychiatric aides* (rev.), 468  
 KINGSFORD, Judith (rev.), 746  
 K.P. for double-duty homemakers (Bell), 884  
 KIRK, Margaret  
 District nurse knows better, 180  
 KIRKPATRICK, Vivian B., 977

## L

- LABORATORY procedures:  
 A summary of clinical (Watson), 601  
 L'ACCREDITATION — où en sommes-nous (McQuarrie), 444  
 LAMP of the wilderness (Spencer), (rev.), 47  
 LAUDER, Helen, 66  
 LAURENTIA, Sister M. & por., 806  
 LAW, Alma  
 Honorary life membership, 48  
 LAWTON, C. (Hobin)  
 Cavernous sinus thrombosis, 120  
 LEAVELL, Lutie Clemson (Stackpole)  
*Textbook of physiology* (rev.), 136  
 LEFEBVRE, Sister Denise, 695  
 LEONE, Lucile Petry, 797, 820  
 LESNIK, Milton J. (Anderson)  
*Nursing practice and the law* (rev.), 556  
 Let's look at accreditation, 368

- LEUKEMIA (Schweisheimer), 724  
 LIBRARIES:  
 Nursing school (Riddell), 798  
 LIFE, profession and school (Clarke), 530, 640, 715  
 LINDEBURGH, Marion  
 Memorial to, 464  
 LONG-TERM illness:  
 Impact of chronic illness (Phillips), 524  
 What it means to be old (Phillips), 611  
 LOUIS-ÉTIENNE, Soeur  
 Schizophrénie, 539  
 LUPIN, Marie  
 Conseils à une étudiante devant faire un stage à la salle d'opération, 832

## M

- MACDONALD, S. (Skerry, MacLean, Black, Kennedy)  
 Radioactive isotopes, 800  
 MACGREGOR, Jean E.  
 In time of need (ed.), 517  
 MACISAAC, Rita, 822  
 Public relations guide, 439  
 MACKENZIE, Mary T. (por.), 337  
 Service, responsibility, nurture, action (ed.), 324  
 MACLEAN, Beatrice A.  
 A nurse's private devotions, 27  
 MACLEAN, J. (Skerry, Black, Kennedy, MacDonald)  
 Radioactive isotopes, 800  
 MACLENNAN, E. A. Electa & por., 804  
 MACLEOD, Agnes J. (rev.), 744  
 MACLEOD, Christina M. & por., 200  
 MACMILLAN award winners, 324  
 MACPHAIL, A. N. (Ferguson)  
*Hospital and community* (rev.), 458  
 MACQUARRIE, Dorothy (MacTavish)  
 Nursing care of patients with lumbar intervertebral disc lesions, 429  
 MACTAVISH, Donalda (MacQuarrie)  
 Nursing care of patients with lumbar intervertebral disc lesions, 429  
 MACKIE, Jean (rev.), 466  
 MALE nurses:  
 A new deal for (Wedgery), 636  
 MALONE, R. S., 690  
 MALLORY, Evelyn  
 Report of Nursing Education Committee, 694  
 MANAGEMENT of acute poliomyelitis (Stott, Fischer-Williams), (rev.), 290  
 MANAGEMENT of lumbar intervertebral disc lesions (Rosen), 423  
 MANITOBA:  
 Historic, 339  
 News notes, 226, 301, 391, 475, 561, 652, 753, 995  
 Our senior citizens (Wilson), (ed.), 421  
 Provincial association activities, 440  
 Winnipeg, the friendly city, 431  
 MANUAL of psychiatry (Stallworth), (rev.), 136  
 MANUEL du service du nursing à l'hôpital, (rev.), 384  
 MARCELLUS, Dorothy & por., 544  
 MARIE, Sister Helen, 805, (por.) 806

# INDEX TO VOLUME 52

MARY Agnes Snively memorial lecture:  
Are we equal to our future (Sanders),  
(ed.), 781  
Sommes-nous en mesure de faire face à  
l'avenir (Sanders), (ed.), 785  
MATHEWSON, Mary S.  
Portrait unveiled, 134  
McARTHUR, Helen G. (por.), 46, 696  
And the world too, 703  
Christmas in Korea (ed.), 949  
McCALLUM, Helen Neil & por., 545  
McCLURE, Ruth Elizabeth & por., 977  
McILWRAITH, Effie C., 476  
McIVER, Pearl, 791  
McKENNA, Frances M.  
*Thresholds to professional nursing practice*  
(rev.), 913  
McLEOD, A. (Foster, Palframan, Shouldice)  
Band's ring, 266  
McMILLAN, Patricia (rev.), 468  
McPHAIL, Dorothy Lyons (Kaufman) &  
por., 38  
McQUARRIE, Frances U., 694  
Accreditation — où en sommes-nous, 444  
Accreditation — what's on the record, 443  
MEANING of rehabilitation (Wellard), 904  
MEANING of *social medicine* (Galdston),  
(rev.), 290  
MECONIUM ileus (Wright, Bullock), 193  
MEMORIAL to Helen S. Peters, 650  
MEMORIAL to Marion Lindeburgh, 464  
MENTAL health:  
Confusing notions of (Stokes), 519  
for nurses (Cruikshank), 95  
MENTAL health for nurses (Cruikshank), 95  
MIGRATION of nurses, 202  
MONTAG, Mildred (Wright)  
*Textbook of pharmacology and therapeu-*  
*tics* (rev.), 745  
MOORE, Edna L. & por., 976  
MOREHOUSE, Carol E.  
Using case histories to learn, 361  
MORTON, H. S. (rev.), 990  
My complaints (Dalton), 197

## N

NATIONAL health week, 30  
NATIONAL immunization week, 751  
NESBITT, Margaret (rev.), 136  
NEUROLOGICAL conditions:  
Cavernous sinus thrombosis (Lawton,  
Hobin), 120  
Hydrocephalus (Jenkinson), 885  
NEUROSURGICAL conditions:  
Management of lumbar intervertebral disc  
lesions (Rosen), 423  
Nursing care of patients with lumbar  
intervertebral disc lesions (MacTavish,  
MacQuarrie), 429  
NEW Brunswick:  
Annual meeting in (Archibald), 130  
Evaluating nursing education, 47  
Honorary life membership (Law), 48  
News notes, 64, 150, 227, 301, 391, 475,  
561, 653, 754  
Provincial association activities, 441  
New deal for male nurses (Wedgery), 636  
NEWFOUNDLAND:  
Provincial association activities, 441  
Two-year educational program, 46

NEW products, 6, 86, 166, 246, 328, 414, 510,  
590, 678, 774, 862, 942  
NEW year greeting (Ramage), (poem), 17  
NEWS notes, 62, 144, 224, 299, 389, 472, 557,  
649, 752, 838, 920, 992  
NORTON, Phyllis (por.), 125  
NOVA Scotia:  
District nurse knows better (Kirk), 180  
News notes, 65, 562, 996  
Provincial association activities, 442  
Refresher course in administration and  
supervision in nursing education, 140,  
550  
NURSES as teachers of science (Reid), 187  
NURSES as women:  
Are we equal to our future (Sanders),  
(ed.), 781  
Sommes-nous en mesure de faire face à  
l'avenir (Sanders), (ed.), 785  
NURSE's private devotions (MacLean), 27  
NURSES' role in civil defence, 186  
NURSES: their education and their role in  
health programs, 347, 696, 791  
NURSING across the nation, 46, 126, 202,  
280, 366, 454, 548, 734, 820, 896, 981  
NURSING assistant:  
Functions of, 280  
With our training we can help  
(Groenewald), 122  
NURSING à travers le pays, 48, 127, 204,  
281, 370, 458, 552, 738, 824, 900, 986  
NURSING care:  
Band's ring (Foster, McLeod, Palframan,  
Shouldice), 266  
Cavernous sinus thrombosis (Lawton,  
Hobin), 120  
Changing attitudes (Phillips), 708  
Child in hospital (Faughnan), 956  
Child with laryngotracheo bronchitis  
(Cecelia), 351  
Diabetes mellitus (Dersco), 617  
Epidermoid carcinoma (Watanabe), 534  
Glomerulonephritis (Doris), 712  
Hydrocephalus (Jenkinson), 885  
Impact of chronic illness (Phillips), 524  
Leukemia (Schweisheimer), 724  
Meconium ileus (Wright, Bullock), 193  
of patients with lumbar intervertebral disc  
lesions (MacTavish, MacQuarrie), 429  
Pediatric setting (Ross), 955  
Quelques considérations sur l'anémie et les  
états anémiques (Tessier), 728  
Radioactive isotopes (Skerry, MacLean,  
Black, Kennedy, MacDonald), 800  
Rheumatoid arthritis (Ziehran), 448  
Role of the nurse in rehabilitation  
(Phillips), 810  
Salt-losing nephritis (Richards, Dodkin),  
537  
Scarlatine plus endomyocardite (Payer),  
891  
Schizophrenia (Stewart), 114  
Schizophrénie (Louis-Etienne), 539  
Service social et le cancer (Chamard), 268  
Staphylococcal pneumonia (Demko), 971  
Student nurse in a pediatric setting  
(Caplan, Dimock), 959  
When a nurse has diabetes (Bell), 627  
NURSING care of patients with lumbar  
intervertebral disc lesions (MacTavish,  
MacQuarrie), 429



## NURSING education:

- Accreditation — où en sommes-nous (McQuarrie), 444
- Accreditation — what's on the record (McQuarrie), 443
- Adventures in science teaching (Alderson), 271
- Creative nursing (Schwier), 875
- Experimentation dans le domaine de (Dion), 445
- Forty years of pilgrimage (Russell), (ed.), 173
- Life, profession and school (Clarke), 530, 640, 715
- Nurses as teachers of science (Reid), 187
- Nurses: their education and their role in health programs, 347, 696, 791
- Soin des enfants (Giroux), 968
- Some considerations on the basic nursing curriculum (Carter), 357

## NURSING manual for psychiatric aides (Crawford, Kilander), (rev.), 468

- NURSING practice and the law (Lesnik, Anderson), (rev.), 556
- NURSING profiles, 38, 199, 543, 624, 804, 976
- NURSING programs at the University of Saskatchewan (Willis), 40
- NURSING research:
  - Improving nursing service (Arnstein), 869
- NURSING school library (Riddell), 798
- NURSING service:
  - Improving (Arnstein), 869
  - Orientation manual (Campion), 447
  - Too many for too few (Girard), (ed.), 93

- NUTRITION:
  - K.P. for double-duty homemakers (Bell), 884
  - You are what you eat, 982
- NUTRITION and diet therapy (Proudfit, Robinson), (rev.), 913

## O

### OBSTETRICS:

- Band's ring (Foster, McLeod, Palframan, Shouldice), 266

### OCCUPATIONAL nursing:

- Role of the industrial nurse in accident prevention (Greville), 112

### OCHSNER, Alton

- Smoking and cancer* (rev.), 136

- OFFICIAL directory, 80, 160, 240, 320, 495, 672, 856, 1014

- OFFICIAL travel agents, I.C.N. Congress, 338

- OGILVIE, Elsie C. & por., 625

### ONTARIO:

- Lying of the cornerstone, 548
- Memorial to Ione Holdsworth, 562
- News notes, 66, 150, 227, 303, 392, 476, 562, 653, 755, 920, 996
- Provincial association activities, 442
- Public health nursing service: appointments, transfers, resignations, 60, 221, 388, 470, 649, 917, 970
- Registered Nurses' Association of, change of address, 940

- OPERATING room nurses (Crouse), 198

- ORDERLY training program (Richmond), 191

- ORIENTATION (Campion), 447

- ORIENTATION manual, 280, (Campion), 447

- OUR senior citizens (Wilson), (ed.), 421
- OWEN, Joyce, 202

## P

- PAIN, breath of (Bromage), 45
- PALFRAMAN, J. (Foster, McLeod, Shouldice)
  - Band's ring, 266
- PARENTS' point of view (James), 963
- PARTINGTON, C. N.
  - Fluid balance, 262

### PATIENT care:

- Social sciences and improvement of, (Brown), 175

- PATTERNS of patient care (rev.), 220

- PAUL of the Cross, Sister (rev.), 218

### PAYER, Hélène

- Scarlatine plus endomyocardite, 891

- PEARSON, Nancy (rev.), 216

- PEDIATRIC setting (Ross), 955

- PEDIATRIC work conference (Flander), 951

### PEDIATRICS:

- Child in hospital (Faughnan), 956
- Counterpane land (Bell), 107
- From little acorns (Butler), 31
- Meconium ileus (Wright, Bullock), 193
- Parents' point of view (James), 963
- Process notes on the work conference (Dimock), 951

- setting (Ross), 955

- Soin des enfants (Giroux), 968

- Some thoughtful conclusions (Flander), 966

- Student nurse in a, setting (Caplan), Dimock), 959

- work conference (Flander), 951

### PEPPER, Evelyn

- Civil defence, 696

- PERCY, Dorothy M., 548, 896, 820

- Signpost at Geneva, 790

### PERRODIN, Cecilia M.

- Supervision of nursing service personnel* (rev.), 140

### PHILLIPS, Elisabeth C.

- Changing attitudes, 708
- Impact of chronic illness, 524
- Role of the nurse in rehabilitation, 810
- What it means to be old, 611

- PHYSICAL therapy after amputation, the treatment of the unilateral lower extremity amputee (Bryce), (rev.), 385

- PHYSIOLOGY and anatomy (Greisheimer), (rev.), 138

- PIKE, M. (rev.), 912

### PLAY:

- Counterpane land (Bell), 107

### POLIOMYELITIS:

- Outlook in, 874

- PORTRAITS unveiled (Mathewson), 134; (Munroe), 568

- POSITIONS vacant, 71, 152, 232, 309, 398, 483, 574, 661, 758, 841, 922, 1002

### POSTGRADUATE courses available:

#### Obstetrics —

- Royal Victoria Hospital, Montreal, 10, 150, 170, 251, 334, 418, 514, 593, 681, 777, 867, 946
- Winnipeg General Hospital, 10, 91, 169, 251, 386, 417, 515, 594, 682, 775, 864, 944

# INDEX TO VOLUME 52

- Operating room —  
Winnipeg General Hospital, 10, 91, 169, 251, 386, 417, 515, 594, 682, 775, 864, 944
- Psychiatric nursing —  
Allan Memorial Institute of Psychiatry, 8, 150, 170, 251, 334, 418, 514, 593, 684, 777, 866, 945  
Hospital for Mental Diseases, Brandon, Man., 11, 91, 169, 251, 329, 417, 515, 594, 684, 775, 866, 944  
Nova Scotia Hospital, Dartmouth, 8, 90, 170, 250, 332, 418, 515, 594, 682, 777, 865, 945
- Tuberculosis —  
Mountain Sanatorium, Hamilton, Ont., 8, 91, 167, 302, 388, 476, 514, 655, 681, 777, 866, 945  
Nova Scotia Sanatorium, Kentville, N.S., 10, 90, 170, 250, 332, 418, 515, 594, 682, 775, 865, 944
- Universities —  
Alberta, 90, 169, 249  
Assumption, of Windsor, 250  
British Columbia, 249, 332, 415  
Dalhousie, 8, 149, 250, 417, 866  
Manitoba, 91, 169, 249, 329, 417, 775, 864, 944  
McGill, 67, 225, 331, 512, 863  
McGill, Montreal Neurological Institute, 514, 655, 750, 779, 946  
McMaster, 7, 148, 167, 248, 330, 416, 511, 592  
Queen's, 10, 90, 167, 945  
Saskatchewan, 253  
Teachers College, Columbia — Heart disease nursing, 442  
Toronto, 329
- PRACTICAL nurse and her patient (Goulding, Torrop), (rev.), 748
- PRACTICAL suggestions:  
New autoclave tape (Norton), 125  
New spectacles aid the deaf, 134
- PRAIRIE convention (ed.), 687
- PREMATURE infants:  
Un enfant est né trop tôt (Saint-Martin), 345
- PRESIDENTIAL address:  
Tomorrow's pattern (Sharpe), (ed.), 597
- PRINCE Edward Island:  
Annual meeting in (Bolger), 50, 984  
News notes, 67, 228, 655, 998  
Provincial association activities, 442
- PRINCIPLES and techniques of psychiatric nursing (Ingram), (rev.), 990
- PROCESS notes on the work conference (Dimock), 951
- PROFESSIONAL ideals:  
My complaints (Dalton), 197  
We cannot come down (Spalding), 435
- PROFESSIONAL training grants, 456
- PROGRAM guide for future nurses' clubs (rev.), 384
- PROGRAM planning, 772
- PROUDFIT, Fairfax T. (Robinson)  
Nutrition and diet therapy (rev.), 913
- PROVINCIAL association activities, 440
- PSYCHIATRIC nursing (Bregg), 183
- PSYCHIATRIC nursing:  
Schizophrenia (Stewart), 114  
Schizophrénie (Louis-Etienne), 539
- PSYCHOLOGY in nursing practice (Crow, Crow, Skinner), (rev.), 446
- PUBLIC health nursing:  
Bifocal approach (Sinclair), 880  
District nurse knows better (Kirk), 180  
Greenhorn on the frontier (Evans), 974  
Quelques nouvelles tendances dans le nursing en hygiène publique, 206  
Société des infirmières visiteuses (Rivard), 196
- PUBLIC relations:  
guide (MacIsaac), 439  
When the nurse is the patient, 127
- PUBLIC relations guide (MacIsaac), 439
- ## Q
- QUEBEC:  
Curriculum talks, 981  
Expérimentation dans la domaine de l'éducation de l'infirmière (Dion), 445  
Future nurses' club, 533  
Montreal General Hospital (alumnae) 50th anniversary, 998  
News notes, 68, 228, 306, 393, 478, 566, 658, 839, 921, 998  
Portrait of Mary Mathewson unveiled, 134  
Portrait of Fanny Munroe unveiled, 568  
Provincial association activities, 442
- QUELQUES considérations sur l'anémie et les états anémiques (Tessier), 728
- ## R
- RADIOACTIVE isotopes (Skerry, MacLean, Black, Kennedy, MacDonald), 800
- RAMAGE, James  
New year greeting (poem), 17
- RANGER, Monique  
Les besoins de l'écolier en matière de santé, 52
- RAWLINGS, Helen (rev.), 745
- RECORD keeping:  
Commentaires, 893
- REHABILITATION:  
Films on, 824  
Meaning of (Wellard), 904  
Miracles — yes or no, 896  
Role of the nurse in (Phillips), 810
- REID, Alma E.  
Nurses as teachers of science, 187
- RELIGION in the life of a nurse:  
A nurse's private devotions (MacLean), 27  
Ethical religious needs of the patient (Frumkin), 263
- REPORT on the experiment in nursing education of the Atkinson school of nursing, Toronto Western Hospital, 1950-1955 (Wallace), (rev.), 58
- RESOLUTIONS:  
Crest in two languages — English and French, 697  
Factual information about nursing in Canada, 697  
Pilot project on evaluation, 698  
Program of accreditation, 697  
Wording of a nursing pledge, 697
- RESPIRATORY conditions:  
Child with laryngotracheo bronchitis (Cecelia), 351



RHEUMATOID arthritis (Ziehran), 448  
 RICHARDS, D. (Dodkin)  
     Salt-losing nephritis, 537  
 RICHMOND, Mary L. & por., 977  
     Orderly training program, 191  
 RIDDELL, Dorothy G.  
     Nursing school library, 798  
 RIVARD, Renée  
     Société des infirmières visiteuses, 196  
 ROACH, Florence Mary & por., 199  
 ROBINSON, Corinne H. (Proudfit)  
     *Nutrition and diet therapy* (rev.), 913  
 ROLE of the industrial nurse in accident prevention (Greville), 112  
 ROLE of the nurse in rehabilitation (Phillips), 810  
 ROSEN, Harold J.  
     Management of lumbar intervertebral disc lesions, 423  
 ROSS, Alan  
     Pediatric setting, 955  
 ROSS, Marian (rev.), 913  
 ROTUNDA *textbook of midwifery for nurses* (Brownie), (rev.), 54  
 ROWE, Harold R. (Flitter)  
     *Teaching physiology and anatomy in nursing* (rev.), 138  
 ROY, Alberte & por., 976  
 ROYAL commission on the economic future of Canada, brief to, 366, 548, 690  
 RUANE, Kathleen (por.), 341  
     Starting from scratch, 341  
 RUSSELL, E. Kathleen, 47, 164, 368, (por.) 173, 624  
     Forty years of pilgrimage (ed.), 173  
 RUSSELL, J. A., 687

S

SAFETY education:  
     Common sense safety precautions, 714  
     The role of the industrial nurse in accident prevention (Greville), 112  
 SAINT-MARTIN, Robert  
     Un enfant est né trop tôt, 345  
 SALAAM aliakum (Sharpe), (ed.), 13  
 SALLE pour enfants brûlés (Tanner), 382  
 SALT-losing nephritis (Richards, Dodkin), 537  
 SAND, Ole  
     *Curriculum study in basic nursing education* (rev.), 219  
 SANDERS, Byrne Hope por., 350, 368, 698  
     Are we equal to our future (ed.), 781  
     Sommes-nous en mesure de faire face à l'avenir (ed.), 785  
 SANDERSON, H. H., 689  
 SASKATCHEWAN:  
     Annual meeting in (Wilson), 898  
     expanding health services (Bentley), 699  
     and its people (Smith), 257  
     New university hospital organizes the nursing service department (Ruane), 341  
     News notes, 68, 151, 229, 394, 478, 660, 756, 921, 1000  
     Nurses' role in civil defence, 186  
     Nursing programs at the University of, (Willis), 40  
     Provincial association activities, 442  
     Service, responsibility, nurture, action (MacKenzie), (ed.), 337

SASKATCHEWAN and its people (Smith), 257  
 SASKATCHEWAN's expanding health services (Bentley), 699  
 SCARLATINE plus endomyocardite (Payer), 891  
 SCHIZOPHRENIA (Stewart), 114  
 SCHIZOPHRENIE (Louis-Etienne), 539  
 SCHWEISHEIMER, W.  
     Hypotension, 53  
     Leukemia, 724  
 SCHWENCK, J. Rae (Goostrey)  
     *Textbook of chemistry* (rev.), 468  
 SCHWIER, Mildred E. & por., 438, 695  
     Creative nursing, 875  
 SELECTED *writings of Florence Nightingale* (Seymer), (rev.), 744  
 SELECTION:  
     Besoins de l'écolier en matière de santé (Ranger), 52  
     Comment vivent les hommes en notre temps, 298  
     Commentaires, 893  
     Conseils à une étudiante devant faire un stage à la salle d'opération (Lupien), 832  
     L'enfant à l'hôpital, 132  
     Importance de dosage ingéré et excrété (Germain), 462  
     Infirmière en obstétrique (Calvé), 742  
     Une innovation qui pourrait réduire les coûts de construction des hôpitaux, 546  
     Les méfaits du bruit et leurs répercussions sur l'organisme humain, 546  
     Les préjugés, 992  
     Petite étude psycho-sociale, 634  
     Quelques nouvelles tendances dans le nursing en hygiène publique, 206  
     Salle pour enfants brûlés (Tanner), 382  
     SERVICE social et le cancer (Chamard), 268  
 SEYMER, Lucy Ridgely  
     *Selected writings of Florence Nightingale* (rev.), 744  
 SHARPE, Gladys J. (por.) 13, 597, 698  
     Salaam aliakum (ed.), 13  
     Tomorrow's pattern (ed.), 597  
 SHAW, E. C. (rev.), 290  
 SHOLTIS, L. A. (Eliason, Ferguson)  
     *Surgical nursing* (rev.), 56  
 SHOLTIS, Lillian A. (Bragdon)  
     *Teaching medical and surgical nursing* (rev.), 56  
 SHOULDS, D. (Foster, McLeod, Palframan)  
     Bandl's ring, 266  
 SIGNPOST at Geneva (Percy), 790  
 SINCLAIR, Adelaide (Macdonald) por., 214, 694  
     Bifocal approach, 880  
 SKERRY, V. (MacLean, Black, Kennedy, MacDonald)  
     Radioactive isotopes, 800  
 SKIN, mirror of emotions (Frumess), 374  
 SKINNER, C. (Crow, Crow)  
     *Psychology in nursing practice* (rev.), 466  
 SMALL, Barbara Joan & por., 543  
 SMITH, Christian  
     Saskatchewan and its people, 257  
 SMITH, Grace (rev.), 468  
 SMITH, Lottie (rev.), 385  
 SMOKING and cancer (Ochsner), (rev.), 136  
 SOCIAL sciences and improvement of patient care (Brown), 175

# INDEX TO VOLUME 52

- SOCIÉTÉ des infirmières visiteuses (Rivard), 196
- SOIN des enfants (Giroux), 968
- SOME considerations on the basic nursing curriculum (Carter), 357
- SOME thoughtful conclusions (Flander), 966
- SOMMES-nous en mesure de faire face à l'avenir (Sanders), (ed.), 785
- SPALDING, Ione E.  
We cannot come down, 435
- SPENCER, June  
*Lamp of the wilderness* (rev.), 47
- STACKPOLE, Caroline E. (Leavell)  
*Textbook of physiology* (rev.), 136
- STALLWORTH, K. R.  
*Manual of psychiatry* (rev.), 136
- STAPHYLOCOCCAL pneumonia (Demko), 971
- STARTING from scratch (Ruane), 341
- STEED, Margaret  
Fun on trains, 185
- STEWART, Ann  
Schizophrenia, 114
- STEWART, Isabel M. & por., 624
- STIVER, M. Pearl  
General secretary's report, 690  
Official notice, 28th biennial meeting, 356
- STOKES, A. B.  
Confusing notions of mental health, 519
- STOTT, C. P. (Fischer-Williams)  
*Management of acute poliomyelitis* (rev.), 290
- STUART, Eugenie (rev.), 54
- STUDENT day activities (Wildfang), 706
- STUDENT nurse in a pediatric setting (Caplan, Dimock), 959
- STUDENT nurses' association:  
of Alberta, 212  
Student day activities (Wildfang), 706
- STUDENTS' health:  
Besoins de l'écolier en matière de santé (Ranger), 62
- SUMMARY of clinical laboratory procedures (Watson), 601
- SUPERVISION of nursing service personnel (Perrodin), (rev.), 140
- SURGICAL nursing (Eliason, Ferguson, Sholtis), (rev.), 56
- T**
- TANNER, J. R.  
Salle pour enfants brûlés, 382
- TAYLOR, Winifred E., 920
- TEACHING medical and surgical nursing (Bragdon, Sholtis), (rev.), 56
- TEACHING methods:  
Adventures in science teaching (Alderson), 271  
Nurses as teachers of science (Reid), 187  
Orderly training program (Richmond), 191  
Using case histories to learn (Morehouse), 361
- TEACHING physiology and anatomy in nursing (Flitter, Rowe), (rev.), 138
- TELEVISION:  
Petite étude psycho-sociale, 634
- TENSION:  
Mental health for nurses (Cruikshank), 95
- TENTATIVE program for the 28th biennial convention, 284
- TESSIER, Eugénie  
Quelques considérations sur l'anémie et les états anémiques, 728
- TEXTBOOK of chemistry (Goostray, Schwenck), (rev.), 468
- TEXTBOOK of medicine for nurses (Joule), (rev.), 466
- TEXTBOOK of pharmacology and therapeutics (Wright, Montag), (rev.), 745
- TEXTBOOK of physiology (Stackpole, Leavell), (rev.), 136
- THERIAULT, Michelle, 394
- THOMAS, Dorothy, 550
- THORPE, Louis (Katz)  
*Understanding people in distress* (rev.), 747
- THOUGHT for spring (Bangham), (poem), 256
- THRESHOLDS to professional nursing practice (McKenna), (rev.), 913
- TICKET of nominations (CNA), 376
- TOMORROW's pattern (Sharpe), (ed.), 597
- Too few for too many (Girard), (ed.), 93
- TORROP, Hilda M. (Goulding)  
*Practical nurse and her patient* (rev.), 748
- TREMBLAY, Claire  
Impressions d'Afrique, 630
- TRENNA Hunter, president, 799
- THRESHOLDS to professional nursing practice (McKenna), (rev.), 913
- TRUTH about cancer (Cameron), (rev.), 990
- TUBERCULOSIS:  
prevention in the far north (Walz), 43
- TWEEDIE, Stuart, 690
- Two-year course in nursing:  
Expérimentation dans l'éducation de l'infirmière (Dion), 445  
Program in Newfoundland, 46  
Report on the experiment in nursing education of Atkinson School of Nursing, Toronto Western Hospital, 1950-55 (Wallace), 58
- U**
- UNDERSTANDING people in distress (Katz, Thorpe), (rev.), 747
- UNIVERSITY hospitals:  
New, organizes the nursing service department (Ruane), 341
- UNIVERSITY programs:  
Nurses as teachers of science (Reid), 187  
Venture in field experience for graduate nurses (Allen), 276
- UNIVERSITY schools of nursing:  
Nursing programs at the University of Saskatchewan (Willis), 40
- UNIVERSITY education for administration in hospitals (Hamilton), (rev.), 54
- USING case histories to learn (Morehouse), 361
- V**
- VANCE, Russell E.  
*Hospital adult education* (rev.), 456  
*Hospital in-service educational training* (rev.), 456
- VANCE, V., 563



# THE CANADIAN NURSE

VENTURE in field experience for graduate nurses (Allen), 276  
 VICTORIAN Order of Nurses:  
     Appointments, transfers, resignations, 61, 538, 837  
 VISITING nursing:  
     Société des infirmières visiteuses (Rivard), 196  
 VITAL statistics, 840

## W

WALL, Margaret Ann & por., 648  
 WALLACE, W. Stewart  
     *Report on the experiment in nursing education of the Atkinson school of nursing, Toronto Western Hospital 1950-55* (rev.), 58  
 WALTERS, Lurline, 202  
 WALZ, Josephine (por.), 43  
     Tuberculosis prevention in the far north, 43  
 WATANABE, Lily  
     Epidermoid carcinoma, 534  
 WATERS, S. Monica (rev.), 54  
 WATSON, E. M.  
     Summary of clinical laboratory procedures, 601  
 WE cannot come down (Spalding), 435  
 WEDGERY, Albert (por.), 636, 691  
     New deal for male nurses, 636  
 WEISS, M. Olga  
     *Attitudes in psychiatric nursing care* (rev.), 385  
 WELLARD, Frank G.  
     Meaning of rehabilitation, 904  
 WHAT about vacation plans (Collins), 109  
 WHAT it means to be old (Phillips), 611  
 WHEN a nurse has diabetes (Bell), 627  
 WHITEFORD, Jean (rev.), 466  
 WHY attend the CNA convention (Carmel), (ed.), 255

WILDFANG, Edythe  
     Student day activities, 706  
 WILLIS, Lucy D.  
     Nursing programs at the University of Saskatchewan, 40  
 WILSON, Helen Christena, 545  
 WILSON, Lola (rev.), 556  
     Annual meeting in Saskatchewan, 898  
 WILSON, Mary Emily, 412  
     Our senior citizens (ed.), 421  
 WILSON, M. Jean (rev.), 219  
 WINNIPEG, the friendly city, 431  
 WITH our training we can help (Groenewald), 122  
 WOMEN's auxiliary in action (Croll), 25  
 WORLD Health Organization:  
     Nurses: their education and their role in health programs, 126, 791  
     Signpost at Geneva (Percy), 790  
     Some considerations on the basic nursing curriculum (Carter), 357  
     That the people be served, 820  
 WRIGHT, Alice L. & por. 471, 548  
 WRIGHT, Doris (Bullock)  
     Meconium ileus, 193  
 WRIGHT, E. Howell (Jeans, Blake)  
     *Essentials of pediatrics* (rev.), 218  
 WRIGHT, Harold N. (Montag)  
     *Textbook of pharmacology and therapeutics* (rev.), 745

## Y

YEARBOOK of modern nursing, CNA contribution to, 548  
 YORK, Richard Y. (Greenblatt, Brown)  
     *From custodial to therapeutic patient care in mental hospitals* (rev.), 912

## Z

ZIEHRAN, Rita  
     Rheumatoid arthritis, 448

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VOLUME 52

NUMBER 1

JANUARY 1956

- 6** NEW PRODUCTS
- 13** SALAAM ALIAKUM.....*Gladys J. Sharpe*
- 18** CHROMOSOME DELETION IN THE RH  
GENOTYPE .....*Gilda G. Graves*
- 21** L'EVOLUTION DE LA CARDIOLOGIE  
ET SES PROBLÈMES.....*Paul David*
- 25** A WOMEN'S AUXILIARY IN ACTION.....*Marie C. Croll*
- 27** A NURSE'S PRIVATE DEVOTIONS.....*Beatrice A. MacLean*
- 31** FROM LITTLE ACORNS.....*Ethelyn Butler*
- 38** NURSING PROFILES
- 39** IN MEMORIAM
- 40** NURSING PROGRAMS AT THE UNIVERSITY  
OF SASKATCHEWAN .....*Lucy D. Willis*
- 43** TUBERCULOSIS PREVENTION  
IN THE FAR NORTH.....*Josephine Walz*
- 46** NURSING ACROSS THE NATION
- 48** LE NURSING À TRAVERS LE PAYS
- 52** SÉLECTION
- 53** HYPOTENSION .....*W. Schweisheimer*
- 54** BOOK REVIEWS
- 62** NEWS NOTES
- 71** POSITIONS VACANT
- 80** OFFICIAL DIRECTORY

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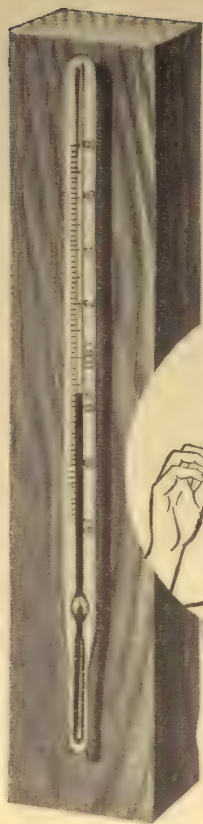
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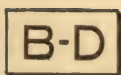


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# Between Ourselves

True to tradition, the president of the Canadian Nurses' Association, **Gladys J. Sharpe**, is our guest editor this month. Her account of the meeting of the ICN Board of Directors in Istanbul, Turkey, last August is useful and informative. After you have read that summary, be prepared for an interest-packed story of places visited, of thrills and experiences on a tour through many parts of this little known country. Perhaps January with its icy blasts, deep snow and frozen radiators would be a good time to go to Turkey! Since it is a physical impossibility for most of us to go perhaps you will draw vicarious enjoyment from the warmth and sunshine of Miss Sharpe's description of her trip.

\* \* \*

Do you ever wonder, when you read part of a story in the daily paper or news magazine, what happened next? Only occasionally at a later date can we find any reference to the story that held our interest. On one story at least we are privileged to bring you some of the inside information. Do you remember the story of the newborn infant in California whose life was saved by the transfusion of blood donated by two Indian women in Alberta? Every newspaper carried the story of the trip made by the R.C.A.F. to Redwood City to deliver the precious shipment of the very rare type of blood. We are delighted to bring you the story behind this news item. **Gilda G. Graves** has written a fascinating account of the extraordinary discovery of an Indian tribe in Alberta many of whose members have this exceedingly rare type of blood. Do not fail to read "Chromosome Deletion in the Rh Genotype."

\* \* \*

Every now and then we receive letters from nurses who write us that they want to get away from routine duties in a city hospital. "Can you tell me where I should apply for a position in the far north . . . in Labrador?" **Josephine Walz** did not write us for any such information but she has been having some truly wonderful experiences while carrying on her tuberculosis prevention program in northern Saskatchewan. It takes courage and stamina to develop a pioneer service of this kind so far from all the comforts and easy living in an urban job. Miss Walz is one of the growing

company of nurses who get great personal satisfaction from the service they can offer to settlers in the vast, underdeveloped areas of our country.

If any of you are interested in breaking away from the ordinary humdrum of routine nursing care and want Adventure (with a capital A,) we suggest that you study the advertisement of the Federal Indian Health Services on page 69 or that of the Grenfell Labrador Medical Mission on page 74. Your life would be very different, to put it mildly.

\* \* \*

It is an essential part of every nurse's training that she should become as familiar with the details of the growth and development of *normal* infants and children as that she should know the signs, symptoms, treatment and nursing care for all of the abnormal conditions she may see. **Ethelyn Butler** used a most refreshing approach to her learning situation when she vitalized every phase of it into a human interest story. You will enjoy reading about the fashion in which the "Stuarts" adapted their pattern of living around their adopted baby — and in the reading you will be reminded of many points of child training you may have forgotten.

\* \* \*

The new pattern in curriculum development that is emerging at the University of Saskatchewan School of Nursing is described for us by **Lucy D. Willis**, who is an assistant professor in that department. Those of you who read Betty Ellison's discussion of the value of operating room experience to the student nurse in our November, 1955 issue will be interested to discover how this experience fits into the total picture of training. The learning opportunities that will be provided in the rural hospital affiliations, that are a part of the students' experience, will be an interesting development to watch.

\* \* \*

If we wish to avoid despair for the future of mankind, we must cherish the hope that the nations of the world will find their way back to humanity and thereby arrive at a deeper and stronger capacity for humanity than ever before flourished on earth.

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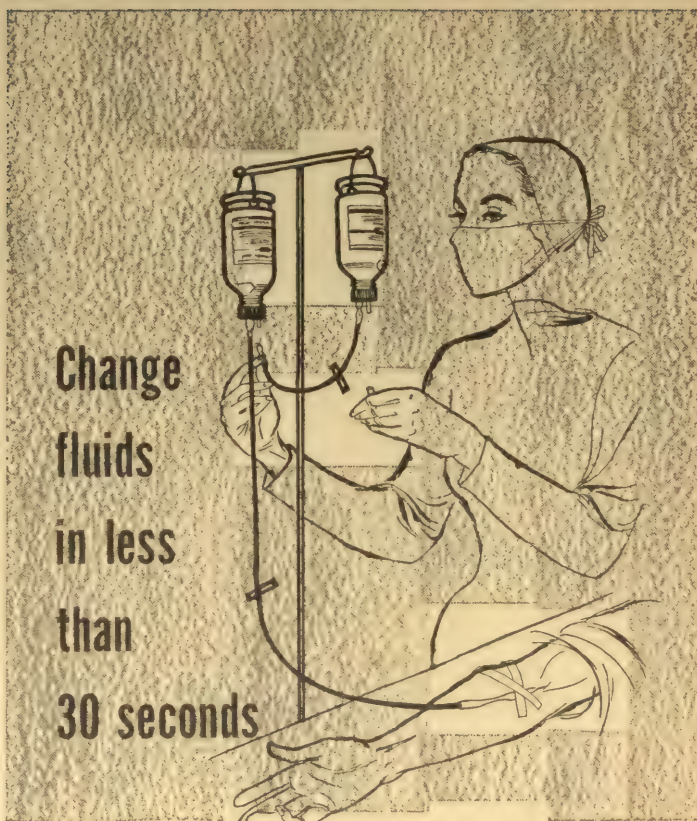
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# THE CANADIAN NURSE

## *L'Infirmière Canadienne*

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## Salaam Aliakum\*

IT HAS BEEN SAID that the pleasures of travel exist best in retrospect and seldom in the instant when experienced. However, one infallible aid to retrospection is to prepare a report such as this, with the hope that you too will share these first brief and still vivid near-East impressions. Why Turkey? was an oft-asked question, and the answer takes us back to the I.C.N. meeting in Rio de Janeiro, July 1953, when the Turkish Nurses' Association invited the Board to hold their 1955 meeting in Turkey and thereby commemorate the 100-year anniversary of the work of Florence Nightingale at Scutari.

Our first impressions of Turkey were at Yesilköy — Istanbul's modern airport, reached after an uneventful trip with brief stops in London, Amsterdam and Munich. We were met by two members of the Turkish Nurses' Association and the husband of a third who expedited the details of passport and customs examination and police registration. Our hostesses knew a few phrases in English, we not a word

of Turkish. The hour-long drive to the largest city and former capital of Turkey took us on a rough, hilly road, through pastures of Biblical shepherds, to the city gate of Istanbul, a narrow



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\*The common Turkish salutation —  
"Peace be with you."

GLADYS J. SHARPE



opening in the 1500-year old wall built by Theodosius II. At intervals we caught the aroma of spicy cooking and heard strains of haunting Turkish music. It was midnight when we reached the fabulous Hilton Hotel and morning before we gained our first magnificent view across the Bosphorus.

Istanbul, formerly Constantinople, is built on many hills, on one of which is the Hilton Hotel. It is the site from which, in 1453, the Moslem Mehmet portaged his ships overland to drop them behind the defense chains guarding the entrance into the Golden Horn. By so doing he conquered the weakened Christian Byzantine Empire.

It can truly be said that the week in Istanbul was constructive and inspiring. There was good discussion of the business items of the Agenda; social events and visits to historic places were wisely interspersed; and from the windows of the room set aside for the meetings, delegates could look across the Bosphorus to the Barracks at Scutari, where, one hundred years ago, Florence Nightingale carried out a revolution in nursing care and hospital administration.

The meetings were presided over by our president, Marie Bihet, and attended by representatives of 26 member associations. Executive secretaries from 16 associations were also present, and for the first time (by unanimous decision of the Board at its opening session) were permitted to participate freely in discussion.

Here are some important matters on which the Board took action:

It was recommended to the Grand Council, that there be a reorganization of the administrative "machinery" of the F.N.I.F., by which it will become the Educational Division of the I.C.N., and be associated with the total program even more closely than at present. One activity of the F.N.I.F. has been the compilation of a bibliography on the life and work of Florence Nightingale. The bibliographer, the former head of the Wellcome Historical Medical Library has drawn to our attention that the collection of Florence Nightingale's letters will be something quite unique and probably much sought after by historical libraries all over the world. It will contain over 10,000 letters and will be the

largest collection of letters written by one individual ever catalogued and published.

New premises for I.C.N. headquarters have been purchased within five minutes walk of Westminster Abbey.

The I.C.N. 11th Quadrennial Congress will be held at the Esposizione Universale Romana Congress Hall in Rome, May 27-June 1, 1957. It was decided that the registration fee will be 5 shillings Sterling, exclusive of accommodation charges. As seating facilities in the Great Hall are limited to 3000 an allocation will be made, each national association being allowed a percentage of places according to its membership.

A meeting of the Grand Council will be held during the Congress week, and (for the first time in I.C.N. history) will be open to all Congress participants.

The theme of the Congress will be "Responsibility" (the watchword given by the retiring president, Miss Gerda Höjer, at the last session of the Congress in Brazil, in 1953). The languages of the Congress will be Italian, French and English.

Exchange privileges of nurses between various countries were studied. In the past two years more than 4,000 nurses have obtained employment in countries abroad and 1200 have studied abroad.

The committee on nursing service presented a valuable report on the need for, and the development of acceptable standards of nursing care throughout the world. A paper of acceptable standards of neurosurgical nursing presented by the Swedish Nurses' Association was accepted for release to all countries.

On the final day of meetings our group, of comparable size to the one led by Florence Nightingale, made a pilgrimage to the Selimiye military barracks in Scutari which includes the historical barracks hospital. The immense square building of three stories surrounds a court. At each corner is a tower and the distance from the entrance to the Nurses' Tower is roughly a quarter of a mile. Visualize a colonnaded corridor, each column effectively draped with the crimson and white national flag, and in front of which stand alternately a member of the garrison forces and a Turkish nurse. A brass band occupies





*I.C.N. Board of Directors at Hotel Hilton, Istanbul.*

one wall. At the signal "present arms," the officers of the garrison honored those of us who represented the 450,000 nurses of the world and remained at salute until all members of the Board had filed past. Then came the stirring roll of drums and a few seconds of deep silence! Such an emotional experience comes but once in a lifetime! Following several addresses from military and other dignitaries, the Board of Directors presented to Miss Esma Deniz, president of the Turkish Nurses' Association a citation:

Here in Turkey the spirit of nursing was born. Here in Uskudar, Florence Nightingale, pioneer of nursing, administrator and statesman, demonstrated to the world the efficacy of nursing care. Here, during the century that has followed her great achievements, her spirit has remained, her memory has been cherished, and her work carried on.

The ceremony concluded with the presentation of flowers to Mlle Bihet by a member of the Turkish Nurses' Association with whom we agreed when, in making the presentation, she exclaimed, "I am so exciting!"

Our business concluded, Miss Stiver and I were free to see and learn more of our environment. Istanbul is the

only city in the world "astride two continents." Europe on the west and Asia on the east, it is situated on the entrance of the Bosphorus which links the Sea of Marmora with the Black Sea. While no longer the capital, Istanbul is still Turkey's most important social, intellectual and commercial centre. The 1950 census gives the population as slightly over one million — that of Turkey as 21 million.

Accompanied by guides who spoke fairly good English we were taken on a tour of the city and, in a most interesting manner, briefed as to its social and archaeological history. We were impressed by the many references to the driving Kemal Ataturk, who it is said, "carefully transplanted the western democratic system like so much new turf on Turkey's ancient culture where it has taken root and grown." We learned how, from 1923 until his death 15 years later, he remade the language and the laws, broke the hold of church on state, organized industry and education, brought women from "Yasmak" to franchise and abolished the Fez. We visited the bedroom in a former Sultan's palace in which Ataturk died, and saw the reverence with which it was viewed by the Turkish nurses in our party.

The old part of Istanbul is surrounded by Byzantine walls repaired and enlarged by the Ottoman Turks in the mid-sixteenth century. Viewing the city from the sea or from any hill, one is impressed by the domes and minarets of its many mosques, some 500 in all. One of the most beautiful visited was that of Sultan Ahmed, better known in the west as the Blue Mosque. Built in 1609 it is the only one in the world sentinelled by six minarets. The luminous blue air is made so by the blue-green mosaic of its enormous dome around the outside of which pigeons circle, while inside, soft Turkish carpets stretch over a floor "the size of four baseball diamonds." As we replaced our shoes we heard the cries of the muezzins, who are chosen for the beauty and power of their voices, calling from the minarets the five Moslem hours of prayer. In response came the faithful, pausing in the courtyards to wash head, arms and feet.

We travelled on the car-ferry from European Istanbul across the Bosphorus to the Asiatic suburbs in 20 minutes and for less than ten cents. On board, the other passengers drank coffee and tea without milk, from tiny glasses standing on saucers. (A demi-tasse of Turkish coffee at the Hotel Hilton cost the equivalent of 40 cents.) In the corner of the deck sat a group of older Turkish women wearing heavy black clothes with shawls covering their heads and held over the lower parts of their faces. Passing up and down Bosphorus were the peaked-sterned, blue and orange fishing boats which daily weave through the submarine nets at the top of the Bosphorus to fish in the choppy Black Sea.

On one trip we passed Leanders Tower where legend says the unfortunate Hero watched her lover Leander drown as he swam to meet her. Our port of call was the Billue Kosk where delicious tea was brewed the Turkish way in a tiny teapot atop a samovar. Here we saw men smoking the long curved waterpipe called the Nagleh which is "fired" by jasmin wood and Persian tobacco, then cooled by being passed through rose-water.

One day we drove to the small seaside village of Shile some 80 miles along the south coast of the Black Sea. There, as guests of a former Egyptian Princess, we were welcomed in homes where we saw flax being spun, woven and embroidered. The houses were as clean as scrubbing could make them, but of course, we unbelievers had removed our shoes. When we saw a row of only partially covered buckets along the wall of the central living-room and learned these comprised the sanitary facilities of the average village home, the presence of many flies and the high rate of infantile diarrhea were understood. The peasant women wore long black Russian-type blouses over fitted white trousers above bare feet with a balaclava-like head dress of yellow. We saw a wedding party leave the Shile village, the bride weeping bitterly, the groom somewhat embarrassed as they sat on opposite sides of a small bus which was taking them and some two dozen guests to their new home in another village.

Our chauffeur doubled as waiter and provided a meal such as we had not dared indulge in during the meetings. An old Turkish proverb says "The spirit gets into a man with the food he eats" and so the Turkish spirit entered us as we enjoyed: *Dolmas* — green peppers stuffed with rice and meat cooked in olive oil, *Güllac* — a typical dessert of starch wafers with pounded almonds, all soaked in milk, white cheese, olives, Yogurt — which the Turks eat as much as we eat ice cream — Anatolian wine, and finally bunches of white, red, green and blue grapes. The strong Turkish coffee acted as a salutary digestive!

From the normal disorder of Istanbul to Greece was a matter of about three air hours. We were greeted at Athens airport by members of the Greek Nurses' Association and a station wagon inscribed "gift from Kanada." We considered ourselves extremely fortunate in that our visit coincided with the "Festival of Athens." A great philosopher once said that the function of drama is to cause a purification of the emotions through pity and fear. That was our experience. We sat on the weather-beaten tiers of the



ancient odeion of Herod Atticus and heard Gluck's presentation of "Orfeo and Euridice" in the original Italian. Problems of an everyday world suddenly became insignificant.

Leaving the theatre and the very seats on which the Greeks had sat for 2,000 years we were awed by the splendor of its natural setting. From under the shadow of the Parthenon, moonlight flooded the Acropolis and the hill of the Muses, and we were transported to the Golden Age. There is no doubt that the ancient Greeks chose ideal sites for their temples and theatres for each fulfills a practical purpose, and also satisfies one's highest sense of beauty. On a spot of awe-inspiring grandeur was built the sanctuary of Aesculepias. It was here that our guide, an instructor at the

Red Cross school of nursing, was in her element. We were guided step by step through the ruins of the world's first hospital, and followed the medical routine prescribed for the people of centuries ago, impressed again and again by the wisdom of the Ancients whose dream oracle — baths and gymnasia — were directed towards prevention and cure just as surely as the psycho-therapy and physiotherapy of 20th century medical science are directed towards rehabilitation.

Here, reflecting on the most beautiful ruins of antiquity, I would take leave of the age of Pericles and return to our 20th century task of meeting the health needs of Canada's people.

GLADYS J. SHARPE  
*President,  
Canadian Nurses' Association*

## A New Year Greeting

May Faith be with thee thro' the year,  
That realizes God is near,  
That fills with peace and life and light,  
That guides thee in the darkest night,  
Whate'er thy circumstances be,  
May steady faith abide with thee!

May hope be with thee thro' the year,  
To smooth thy way and give thee cheer,  
To sing to thee in cloudy day,  
To pour on thee her gladdening ray,  
However drear thy lot may be,  
May heartening hope abide with thee!

May love be with thee thro' the year,  
A love that shall make duty dear,  
That breathes in word and shines in deed  
That's richer, grander far than creed,  
That's quick to feel and do and see,  
May strengthening love abide with thee!

May God be with thee thro' the year,  
Thy hand to hold, thy path to clear,  
To feed thee on the bread of life,  
To crown with victory in the strife,  
In this and in the world to be,  
May God himself abide with thee!

JAMES RAMAGE

### In 1956 may you have —

Enough happiness to keep you sweet;  
Enough trials to keep you strong;  
Enough sorrow to keep you human;  
Enough hope to make your heart sing;  
Enough labor to keep you from rust;  
Enough leisure to make you broad;  
Enough religion to make you value the best;  
Enough of the love of Christ to make you serve.

Things cannot always go your own way.  
Learn to accept in silence the minor aggravations, cultivate the gift of taciturnity and consume your own smoke with an extra

draught of hard work, so that those about you may not be annoyed with the dust and smoke of your complaints.

— SIR WILLIAM OSLER



# Chromosome Deletion

## in the Rh Genotype

GILDA G. GRAVES, B.N.

**I**N REDWOOD CITY, California, a baby was born by Caesarean section. Newspapers over the entire North American continent carried news of her condition. Radio stations in the United States, Canada, and as far away as Lausanne, Switzerland, informed their listeners in both French and English that baby Denise Robertson had survived.

The story behind the press releases was as fascinating as the medical case itself. Baby Denise had been transfused, following her birth, with blood donated by two Canadian women of Indian extraction — two, of only three known donors, of sufficient age and rare blood type, who could have given her the precious chance of life.

The story, of course, goes further.

In the Rh genotype there are two chromosomes with six genes, two pairs of three. They are lettered in the following manner: cde/cde. One set is transmitted by the mother, the other by the father. If any of these six genes is expressed by a capital letter CDe/cde or cDE/cde, or any number of possible variations, the individual is Rh positive. If expressed in small letters, with the absence of even *one* capital letter, the individual is Rh negative — that is, cde/cde. To establish which of the letters are present, the blood cells are tested with antisera C, antisera D, antisera E, and antisera c, and antisera e (small d being unavailable.) If agglutination occurs with large anti-C for example, you would know that the serum being tested would have a large C on at least one "side" of the division or chromosome. Similarly, if agglutination occurs with anti-small c serum you could assess that the patient possesses a small c gene on the other "side"

or chromosome. The only unknown is the small d gene. When the patient's cells are negative (are not agglutinated) by anti-D, the small "d" is believed to be present — as in the Rh negative cde/cde.

So it progresses, with the D, and E, e antisera until the entire genotype can be worked out (excepting d).

In 1950, Dr. R. R. Race of London, England, discovered an extremely rare case of chromosomal deletion, where an individual was found to possess no c,C, and e,E, genes, and the blood genotype was expressed -D-/-D- the patient being Rh positive.

Until 1954, only four such persons had been discovered in the entire hematological world — Dr. Race describing one case, Drs. Waller, Sanger and Bobbitt, one case in 1953, Dr. Phillip Levine of the Ortho Research Foundation, Rarities, New Jersey, also describing one case. In all four of these isolated cases, the familial genealogy and relative blood testing, drew forth no new cases.

Then in March, 1954, a thirty-one year old woman of Indian descent was admitted to the Misericordia hospital, Edmonton, with a hemoglobin of 8.5 gm. per cent on admission. Cross-matching by the Canadian Red Cross Blood Transfusion Service showed her to be group O, Rh positive, and yet none of the 22 bottles of Group O Rh positive blood, held at the bank, matched the patient's specimens.

It was realized that here must be an extremely rare type of blood. Specimens were sent to Toronto, and to Dr. Levine who confirmed this fact. Rarest of medical rarities — her blood proved to be a chromosomal deletion -D-/-D-.

As her hemoglobin further dropped to 5.8 gm. per cent, relatives were called for cross-matching, and one sister's blood was compatible in saline, albumin and indirect Coombs method.

---

Miss Graves has joined the faculty of her Alma Mater, the General Hospital, Edmonton, Alta.

After only 250 cc. had been administered the transfusion had to be discontinued. This could have been a pyrogenic reaction but could also have been due to the fact that in 1951-52, the patient had been given a total of eight transfusions of 500 cc. each of blood containing C,c, and E or e antigens to which she had developed antibodies. Her sister's blood also contained anti-e and probably anti-c resulting from three previous pregnancies and two transfusions. At the time of the donation, she was in the sixth month of another pregnancy at which time the antibody level was further increased.

Dr. D. I. Buchanan, Provincial Director of the Canadian Red Cross, then began his quest, which continues after 18 months, as elusive as when commenced. Blood specimens were obtained from the original patient, her husband, and family, and samples were sent to Dr. Race and Dr. Levine for confirmation of results. Unbelievably, it was found that the patient had married a man who also possessed the rare deletion on one side CDe/-D-. This had no known precedent in medical history.

Since, at that time, I was the nurse in charge of the Edmonton Indian Agency, Indian Health Services, and knew so many of the relatives of these people, Dr. Buchanan asked me to assist him in obtaining blood specimens of the family.

Knowing these people well, and knowing of their close intermarriages (the original patient was second cousin to her own children) and the magnitude of the groups, we needed some guide to selectivity of blood specimens.

Dr. Buchanan had been asked to write a paper on the original case for the International Convention of Hematology in Paris in September, 1954, and the paper was to be ready by June. Since it was already April, and the roads were quagmires of mud we could not waste time.

Knowing that the entire group were Roman Catholics, I realized that at least the deaths, baptisms, and formal marriages had been faithfully recorded by the Oblates of Mary Immaculate order, who have been working with

this particular group since 1845. The hub of this wheel was the Parish of St. Albert, where by rare good luck, we discovered the parish priest, Father Emile Tardif, o.m.i., to be the ideal partner we needed.

For the next two months Father Tardif and I spent every available moment reading page after page of old church records; St. Albert, Ville-neuve, Rivière Qui Barre, Lac Ste. Anne, and even to Lesser Slave Lake. We sent to Quebec for information. We pondered over minutely small handwriting long faded with age, checking and rechecking. Two months later, as we eased aching fingers and burning eyes, we realized that we had traced over 1650 people, through six generations, back at least to the year 1750.

Now, as I met these people in my daily travels, all those who belonged on our "family trees," in the direct lines of descent, further augmented our information. They willingly gave a blood specimen. More elusive people were sought on our muddy expeditions by station wagon, panel, team, or on foot until we had collected over 150 blood specimens. We found 24 people with the deletion on one or both sides of the genotype!

The first paper on the mating of rare chromosomes was presented in Paris in September 1954 by Dr. George Miller, National Director of Red Cross, Toronto. The ten minutes allotted for this paper were doubled due to the extreme interest of the delegates.

A second paper was presented in Toronto at the Canadian Red Cross meeting in June, 1955, and a third on the successful completion of a pregnancy of a -D-/-D- mother and a complete chromosome father, at the joint British Canadian Medical convention in June, 1955, in Toronto.

When it was found, at the Sequoia Hospital, in Red Wood City, that Mrs. Nadine Robertson, an obstetrical patient, had a missing E-e gene, an appeal was made to Dr. Levine for assistance in locating blood for the expected complete replacement of blood that the baby would require. Knowing of our work, he suggested an immediate contact through the Red



Cross. The California hospital authorities notified the National Office of the Canadian Red Cross in Toronto, and California joined Alberta in an international effort to save the life of a yet unborn child.

Dr. Buchanan knew he had three donors whose blood would match, being universal donor type O, Rh positive as was Mrs. Robertson. Since one donor had already given 1500 cc. of blood in February for his sister's delivery, it was decided to take the two sisters' blood — both group O, Rh positive —D—/—D—. Since they possessed no cC/eE, there could be no reaction to Mrs. Robertson's antibodies that she had developed from the pregnancy. She possessed no small e, that her husband had transmitted to their unborn child.

Thirty-five miles northwest of Edmonton to the Michel Band, Dr. Buchanan and I went by station wagon and, completing the trip by horse and wagon, we obtained the first donation. The next day Dr. Buchanan drove to Marlborough, 140 miles west of Edmonton for the second donation.

Tests completed; the blood cleared through customs; special filters provided to prevent the bottles bursting at high altitudes; the blood was taken by an R.C.A.F. jet to California. On arrival the blood was spun down a centrifuge to remove all the plasma (the antibodies present from the donor's transfusions and pregnancies are in the plasma) and the packed cells were then washed in saline (antibodies also coat the outside of the cells). The blood was then reconstituted in group AB antibody free plasma.

The replacements were carried out through the baby's umbilical vein. After the cut-down incisions of the ankles had healed, baby Denise joined her ten-year old sister Susan at home with her mother and father. And no happier than they were two Canadian women,

of Indian ancestry, who wanted no thanks or praise. They were truly happy that they had saved the life of a baby by their own generosity.

Now the publicity has died, and one can barely recall the event. Yet the work will continue. Partial deletions are still found as we explore the fringes of our two groups and there are many questions still awaiting answers. Why do their cells agglutinate in saline with blocking anti-D? Why did the c or C and e or E drop off in the first instance? Is it due to some weird transmutation or freak of nature, or do these people possess some other factor — an inhibitor or destroyer, that Father Tardif and I like to call our "X" factor for want of a better term? What is filling in the void created by the absence of four out of the six genes? Is the remaining —D— chromosome a more complex factor than is known or might they have a chromosomal type for which a testing antisera is, as yet undiscovered?

My main query is unanswered. Why did our mother with —D—/—D— genotype deliver a baby of the identical —D—/—D— genotype when the father was of genotype CDe/cDE? If he transmitted one or other of the chromosomes CDe or cDE what happened to the c, C or e, E in the baby's genotype? Of course, a simple explanation is that he was not the father, but men of —D— type are rare and the mating with a deletion should not have caused the increased antibody titre up to some six weeks before full term, the extremely dark amniotic fluid, or the obvious distress of the fetus in utero as ascertained by the extremely rapid and weak fetal heart tones. Could these symptoms possibly have been caused by the breaking down or extrusion of the C, c or e, E of the father's genes?

These questions and countless others may never be answered. Still the research continues as we plow through the mud or snow in our own quest for information.

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In spite of their high efficiency mechanical respirators are sometimes unable to deliver as much oxygen as needed to patients paralyzed by bulbar poliomyelitis. Dr. Gunnar Miörner and collaborators in Malmo,

Sweden, have found that such patients can be helped by artificially lowering their body temperature. The procedure decreases the amount of oxygen they require.

— COMMUNICATIONS ASSOCIATES INC.



# L'Évolution de la Cardiologie

## et ses Problèmes

PAUL DAVID, M.D.

### LES GRANDES ÉPOQUES DE LA CARDIOLOGIE

I — *Époque anatomique et physiologique*: Les époques de la cardiologie sont celles de la médecine en général. Ce qui nous paraît simple aujourd'hui a exigé des siècles de minutieuses observations. Petit à petit s'édifia la compréhension anatomique du cœur, muscle puissant dans lequel sont placées quatre cavités. (Galien 138-201 A.D., Ibn an-Nafis 1210-1288). Une cloison sépare le cœur gauche du cœur droit mais oreillette et ventricule communiquent par des orifices sur lesquels sont fixées des valvules tricuspidiennes et mitrales qui alternativement les ouvrent et les ferment. Le ventricule droit reçoit le sang des veines caves et il le chasse dans l'artère pulmonaire, le ventricule gauche le sang des veines pulmonaires qu'il éjecte dans l'aorte. A l'origine de ces artères, sont placées des valvules en nid de pigeons dites pulmonaire et aortique. On identifia les diverses structures du cœur dont la masse musculaire, myocarde, est enveloppée au dedans par l'endocarde et au dehors par le péricarde. Le microscope permit une étude détaillée de ces structures à leur état sain et pathologique. (Van Leeuwenhoek 1632-1723).

Beaucoup plus tard et c'est la période physiologique, on identifia le jeu de la circulation sanguine. Sang veineux arrivant au cœur droit et transformé par oxygénation en sang artériel dans le poumon pour être chassé par le cœur gauche dans la grande circulation (Harvey 1578-1657). La force de propulsion du ventricule gauche fut mesurée (Hales 1677-1761). Les lois de la contraction cardiaque furent décrites (Starling 1866-1927).

Si la physiologie du cœur normal est maintenant bien connue, la physiopathologie du cœur malade présente encore aujourd'hui bon nombre de mystères.

II — *Époque clinique*: La découverte du stéthoscope (Laennec 1781-1826) ouvre cette époque extrêmement riche et qui fut l'époque glorieuse de la médecine française en particulier. Mais tous les pays de l'Europe civilisée ont édifié cette médecine d'abord strictement clinique, c'est-à-dire, reposant sur des symptômes et des signes visibles, palpables ou audibles. Puis la clinique s'est enrichie d'appareils rendus accessibles par les progrès de la physique. Les rayons X (Roentgen 1845-1922) et l'électrocardiographie (Einthoven 1860-1927) devinrent les instruments toujours indispensables de la cardiologie moderne.

Les bruits et les souffles anormaux furent décrits et interprétés à la lumière des observations anatomiques. On identifia le rôle de la syphilis, maladie courante à l'époque, sur l'aorte et les valvules sigmoïdes aortiques. Les rapports entre le rhumatisme articulaire aigu et les lésions valvulaires furent codifiés dans les lois célèbres de Bouillaud (1796-1881). Les troubles du rythme ont été classifiés. Le symptôme angineux fut décrit (Heberdeen 1710-1801) et ses rapports avec l'arbre coronarien établis. L'occlusion de ces vaisseaux et l'infarctus du myocarde rentrèrent définitivement dans le chapitre des cardiopathies (Herrick 1912). L'hypertension et ses conséquences vasculaires et cardiaques sont depuis déjà longtemps fixées. Signalons le travail de pionnier du docteur Maude Abbott de Montréal dans le domaine des maladies congénitales (1869-1940).

En même temps que s'édifia la cardiologie clinique on a établi une thérapeutique rationnelle dont plusieurs médicaments sont encore d'usage

Docteur David est directeur de l'Institut de Cardiologie de l'Hôpital Maisonneuve de Montréal.

courant tels la digitale (Withering 1785, Nativelle 1872), la quinidine (Wenkebach et Frey 1918), les salicylates.

III — *Epoque Chirurgicale*: Nous vivons actuellement cette époque qui débuta vers les 1945 à Baltimore lorsque Blalock et Taussig imaginèrent une technique chirurgicale pour améliorer la condition des bébés et enfants bleus. Leurs succès précipitèrent des recherches qui s'étendent aujourd'hui à la correction chirurgicale de toutes les maladies congénitales et acquises. Il faut souligner que tous ces exploits chirurgicaux, dont la presse et les revues à grand tirage sont remplies, ont été rendus possibles par l'avancement des sciences connexes à la chirurgie, en particulier l'anesthésie. Citons quelques-uns seulement des pionniers dont les noms resteront probablement dans les annales des progrès de la chirurgie mondiale ou locale — Blalock, Baltimore; Gros, Boston; Crawford, Stockholm; Bailey, Glover, O'Neil, Philadelphie; Murray, Toronto; Brock, Londres; Mercier-Fauteux, Gagnon, Vineberg, Montréal.

Il est réconfortant de vivre cette période où les chirurgiens du monde entier rivalisent d'audace et d'ingéniosité pour le seul intérêt des malades du cœur et des vaisseaux. Il est inquiétant de suivre cette course non moins spectaculaire du développement atomique à laquelle participent les physiciens de génie de tous les pays, course qui prépare possiblement la destruction d'une partie de l'humanité.

Nous dirons plus loin quelle attitude me semble saine et raisonnable de la part du médecin et de l'infirmière devant les progrès ahurissants et réels de la chirurgie. Nous parlerons aussi des problèmes sociaux et économiques qui vont de pair avec cette thérapeutique nouvelle.

#### LES MALADIES DU COEUR AUX DIFFERENTES ETAPES DE LA VIE

*Les premières années*: Pour des fins pratiques, cette première étape s'étendra de la naissance à cinq ans. Les cardiopathies observées sont essentiellement congénitales. Leur incidence dans notre milieu est certainement

supérieure à ce que laisse soupçonner l'expérience hospitalière courante. Beaucoup de lésions congénitales sont découvertes après la cinquième année faute d'examen plus précis avant. A l'Institut, nous avons confié au Docteur Ghislaine Gilbert ce chapitre de la cardiopathie. La congénitalité cardiaque pose au cardiologue deux problèmes: celui du diagnostic et celui du traitement, l'un et l'autre étant intimement associés.

Il est important d'avoir une claire vision et une saine compréhension de nos pensées lorsqu'un médecin nous réfère ou des parents nous amènent un enfant porteur d'une cardiopathie congénitale. Avant l'ère de la chirurgie, le diagnostic était un acte de gymnastique intellectuelle qui n'aboutissait à aucune sanction thérapeutique. On pouvait sans aucune importance pour l'enfant ni les parents commettre toutes les erreurs possibles de diagnostic. Nous ne pouvions rien faire d'autre que d'assister au cours inexorable de la maladie. Or, nous savons que la survie d'un enfant porteur d'une lésion quelconque congénitale dépasse rarement la vingtième année. Nous savons qu'en très grande majorité ces enfants ont un retard remarquable de croissance. Nous savons que trois fois sur cinq aujourd'hui une cure chirurgicale peut guérir ou améliorer ces enfants. Pour nous, cardiologues, convaincus de ces faits, le choix est fait. Nous proposons une opération chaque fois que la chose est possible c'est-à-dire chaque fois que la lésion dont est porteur l'enfant est susceptible d'être guérie ou améliorée par un acte chirurgical. Mais, et sur ce mais, j'insiste, il faut opérer exclusivement sur des diagnostics certains. Les types de lésions congénitales du cœur sont nombreux et les techniques chirurgicales n'en corrigent actuellement qu'un certain nombre. Si dans le langage courant on entend dire qu'un enfant a un cœur congénital cela ne veut pas dire que tous les enfants qui ont un cœur congénital ont tous la même maladie c'est-à-dire la même lésion. Afin d'apporter plus de lumière sur ce point mal compris du public et de bon nombre de médecins, permettez-moi d'insérer une classification des principales cardiopathies, classification que



nous avons, en collaboration avec le Docteur Gilbert, déjà publiée dans l'Union Médicale.

Classification des cardiopathies congénitales cyanogènes et acyanogènes d'après le Dr. H. B. Taussig:

MALADIES CYANOGENES  
(shunt veinoartériel)

A — Avec débit pulmonaire diminué:

1. Tétralogie de Fallot
2. Trilogie de Fallot
3. Pentalogie de Fallot
4. Atrésie triscuspidienne
5. Transposition vasculaire avec sténose pulmonaire
6. Tronc artériel commun avec circulation bronchique
7. Ventricule unique avec sténose pulmonaire
8. Maladie d'Ebstein avec communication interauriculaire
9. Hypertension pulmonaire congénitale (PPH) avec persistance du foramen ovale.

B — Avec débit pulmonaire augmenté:

1. Complexe d'Eisenmenger
2. Anévrisme artérioveineux pulmonaire
3. Syndrome Taussig-Bing
4. Transposition vasculaire sans S.P.
5. Tronc artériel commun avec implantation directe des pulmonaires sur le tronc artériel
6. Ventricule unique sans S.P.

MALADIES ACYANOGENES

A — Avec shunt artérioveineux:

1. Communication inter-ventriculaire
2. Communication inter-auriculaire
3. Persistance de l'ostium primum
4. Persistance de l'orifice auriculo-ventriculaire commun (A. V. Communis)
5. Syndrome de Lutembacher
6. Anomalies du retour veineux
7. Persistance du canal artériel
8. Communication aortopulmonaire (aortic septal defect)
9. Anévrisme du sinus de Valsalva
10. Anévrisme artérioveineux systémique.

B — Sans shunt:

1. Sténose pulmonaire isolée
2. Sténose aortique et subaortique
3. Coarctation de l'aorte
4. Arc aortique double (vascular ring)
5. Sténose mitrale.

C — Autres malformations:

1. Anomalies des artères coronariennes
2. Fibroélastose
3. Maladie de Fiedler
4. Maladie de Van Gierke
5. Tumeur auriculaire
6. Bloc auriculo-ventriculaire
7. Méthémoglobinémie congénitale
8. Kyste et tumeur du péricarde.

En conclusion, seules les lésions opérables peuvent évidemment être opérées avec succès. Dans nul autre chapitre de la cardiologie doit-on être plus précis que dans celui-ci et c'est pourquoi tous les raffinements de la cardiologie moderne sont employés. Un certain nombre de cardiopathies congénitales sont d'un diagnostic facile aux seuls examens de routine cardiologique, c'est-à-dire, clinique, radiologique et électrocardiographique tels la coarctation de l'aorte et le canal artériel; d'autres résistent à ces examens courants et pour eux furent imaginées des techniques plus récentes de diagnostic, le *cathétérisme des cavités* cardiaques et de l'artère pulmonaire et l'*angiocardigraphie*. Résumons ces techniques qui pour un certain nombre d'entre vous sont peu ou mal connues.

CATHÉTÉRISME DU COEUR

Par une veine du pli du coude, sous anesthésie locale, est introduit un cathéter spécial très solide quoique flexible et opaque aux Rayons X. Il est acheminé vers l'oreillette droite, passe la tricuspide dans le ventricule droit et franchit les sigmoïdes pulmonaires vers le tronc commun et les branches de l'artère pulmonaire. L'opérateur et le radiologue suivent sous écran fluoroscopique le trajet du cathéter qui peut, avec certains types de lésions, emprunter des chemins anormaux dans l'oreillette gauche par une communication interauriculaire



dans le ventricule gauche par une communication interventriculaire. Mais en dehors de suivre le trajet de la sonde, cet examen a deux buts précis :

1 — La mesure des pressions dans les diverses cavités, mesures qui renseignent sur les obstacles valvulaires ou infundibulaires possibles ou sur des apports supplémentaires de sang par des communications anormales.

2 — Le prélèvement d'échantillons sanguins aux différentes étapes. Ces échantillons sont prélevés dans des éprouvettes sans couvert de parafine et leur contenu en O est examiné au laboratoire au Van Slyke ou par lecture directe à l'oxymètre. Des variations significatives du taux d'oxygénation dans les diverses cavités examinées sont les éléments importants pour le diagnostic de présence ou absence d'un shunt.

#### ANGIOCARDIOGRAPHIE

Examen qui consiste à injecter rapidement par voie veineuse une substance radiopaque et à sectionner le passage de cette substance par des prises rapides de clichés sous une ou deux incidences. Le but de cet examen est de suivre dans le cœur le temps et l'intensité de l'opacification des différentes cavités, voies d'apport et voies de débit. Nous nous servons d'un appareil Suédois, un Schoenander, qui permet d'impressionner des films sous deux incidences simultanément à la vitesse que nous fixons avant l'examen à 2, 4 ou 6 films à la seconde. La substance de contraste utilisée chez

nous est de l'urokon à 70 pour cent. Nous tirons 60 films, 30 sous chaque incidence.

Nous sommes loin d'un diagnostic stéthoscopique ! Il n'est pas du cadre de ce travail de discuter les limites de ces examens qui n'éclairent pas automatiquement tous les mystères. J'aimerais souligner la dépense considérable que supposent ces examens et le personnel énorme mis en activité. Le cathétérisme demande une équipe qui, à l'Institut, comprend deux médecins, un radiologiste, une technicienne en radiologie, une technicienne de laboratoire, une garde-malade et un physicien. Chaque examen prend entre deux et trois heures. L'analyse des gaz d'un seul examen demande un minimum de six heures de travail. Que dire du temps que doit prendre le radiologue pour examiner dans ses plus petits détails soixante films ! Il faut également avouer que ces examens présentent un risque. Les accidents sont rares mais possibles, fait que nous révélons chaque fois aux parents. Nous sommes cependant moralement bien convaincus qu'il est infiniment moins grave de faire l'un ou l'autre ou les deux examens que d'opérer sur un diagnostic d'à peu près. Presque tout enfant porteur d'une lésion congénitale dont le thorax est ouvert et chez qui le chirurgien ne fait rien meurt des suites de cette opération inutile. Depuis l'ouverture de l'Institut, nous avons fait 85 cathétérismes avec un décès dans les vingt-quatre heures et 64 angiocardioographies sans incident mortel.

*(La suite au prochain numéro)*

## Nursing Sisters' Association

The Winnipeg Unit had an active and interesting year in 1955. The annual dinner meeting was held in the Business and Professional Women's Club. Mrs. E. A. Rabson, national president, stressed the aims of the association in her address. These were: to stimulate friendship among members; to work for national unity and international peace; to give aid and comfort to nurses in need.

Three general meetings were held during

the year. A raffle was conducted in conjunction with the annual spring tea, the proceeds being used for welfare work. The Remembrance Day tea was held in November. Mrs. F. Sharp, president, and Miss E. Hudson represented the Unit at the Memorial Day service when Mrs. Sharp placed a wreath on the Cenotaph. Plans are being made to welcome and entertain the nursing sisters who attend the biennial convention in June this year.

# A Women's Auxiliary in Action

MARIE C. CROLL

THE WOMEN'S AUXILIARY of Victoria Hospital, London, Ont., was organized in April, 1924, when 12 members, who had been specified and appointed by the Hospital Trust, met and elected their officers. Twenty-five associate members joined the Auxiliary soon afterwards. Now the membership is about 350. It fluctuates as new members join and old members neglect to renew their membership fees which are only 50 cents.

The object of the Auxiliary is "To assist in every way possible the Hospital Trust, the Superintendent, and the Superintendent of Nurses in matters pertaining to Hospital patients, nurses or equipment." (Quoted from Constitution) It is affiliated with the following:

1. Local Council of Women
2. Good Will Industries
3. Women's Hospital Auxiliary of Ontario
4. National Hospital Association

The Board consists of 20 members, 10 elected each year for a two-year term.

Tag Day, an annual affair, is held on the Saturday nearest Hospital Day, May 12th. This is the only money raising effort for the Auxiliary as a whole and the only time in the year when they go to the public for funds. One hundred fifty members and 260 school children assisted with Tag Day last year, when \$1,500 was raised.

The Auxiliary is composed of 12 committees or groups, each doing its specific work. Each member is urged to assist with the work of the Auxiliary by belonging to one of these committees. Some of these groups raise money to carry on their work, while others are purely service groups. The smallest group has 12 members, while the largest has over 60 members.

Each February, a Membership Tea is held at the nurses' residence when

new members are welcomed, and old members may come and renew friendships as well as their membership. Each member then joins the group or groups of her choice, to carry on the work in which she is most interested.

## COMMITTEES

1. *The Membership Committee* is in charge of the Membership Tea and all social affairs as well as the memberships.

2. *The Literary Committee* operates a lending library of books and magazines for the use of the hospital patients. The members of this committee take turns with a cart which is taken twice weekly around to the patients in the wards, loaded with magazines and books donated by members and their friends. They visit with the patients on their rounds. About 30 members are on this committee.

3. *Entertainment and Cheer Committee* provides special treats for ward patients at Easter, Thanksgiving and Christmas. Fruit, candy and cigarettes are arranged on the patients' trays as well as special gifts at Christmas, some of which are articles made by the members, such as bed-jackets. Bridge parties and rummage sales are their main sources of revenue. This group furnished a three-bed room in the new wing at a cost of \$1,000 the money being raised in addition to the sum required for their regular work. They have 25 members.

4. *National Council of Jewish Women* visit their own patients and entertain relatives and friends of out-of-town patients. Their money is raised through voluntary subscription. They furnished a two-bed room in the new wing at a cost of \$750.

5. *Flower Committee* places flowers in the wards, at the hospital entrance, Cancer Clinic, x-ray department and nurses' residence weekly. Money for this work is raised by private donations (sometimes talent money) within the group. They have about 30.

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Mrs. Croll is president of the Women's Auxiliary of Victoria Hospital, London, Ontario.



6. *Nurses - in - Training Committee* provides entertainment for student nurses. Parties are given in the fall and at Christmas. A reception and tea on graduation day make this a special occasion for the nurses' relatives and friends. Sick nurses are remembered with cards and magazines. Four community concert tickets are purchased for the use of the nurses and given out at the discretion of the director of nursing. As a special project this group is gradually furnishing a roof garden on the nurses' residence. There are about 30 members. The work of this group is much appreciated by the director of nurses who would like the Auxiliary to extend its work for the nurses.

7. *Motors Group*, which consists of only 12 members, meets regularly for social affairs and raises its money among the members. Transportation for student nurses is provided at graduation and on other special occasions. Theatre and concert tickets are provided by this group also.

8. *Prenatal Committee*, one of the largest groups with a membership of about 40, assists in the obstetrical wards and operates a gift shop in the hospital. Their very smart and modern new shop in the main corridor of the hospital was opened last June. It is operated from 2-4 and 7-9 daily by the members of the group, who also make the knitted and hand-sewn baby garments which are for sale, as well as toys etc. Two Isolettes were donated by the group in 1954 at a cost of \$825. Two mobile sitz baths at a total cost of \$465 were given in 1955, as well as the office furnishings for the nurse in charge of the obstetrical ward, at a cost of nearly \$600.

9. *Visiting and Service Committee* stands ready to give personal service to patients who may require it. This group has offered assistance in the psychiatric ward when an occupational therapist is available. A dessert bridge in April provided them with funds for material and equipment. They have about 20 members — nearly all young doctor's wives.

10. *The Educational Committee* awards a scholarship of \$350 each year for graduate work at the University of Western Ontario School of Nursing

to the new graduate who stands highest in her class. Several tickets for London Little Theatre are also provided for the student nurses. Money for these projects is raised through an annual Garden Tea in June. Last year the membership of about 60 raised \$425.

11. *The Cancer Committee* serves coffee and cookies three mornings each week to the patients in the Cancer Clinic — there are as many as 30-40 patients each time. All equipment for making and serving the coffee, as well as the coffee, is supplied by the committee. Tea was served at the formal opening of the Cancer Clinic (Fall, 1954), by the group. Magazines, flowers and newspapers are also supplied. A large tea is held in May to assist the membership of 30-35 in raising the funds required for these projects.

12. *The Coffee Shop*, that is owned and operated by the Auxiliary, is our chief source of revenue. It is managed with all paid help under the supervision of a committee consisting of the past presidents. In June 1954, the Coffee Shop was opened in new quarters in the main corridor of the new wing of the hospital. It was completely furnished by the Auxiliary at a cost of over \$18,000. It is very bright and modern and provides a wonderful service to the hospital patients and staff.

In addition to the contributions of the various committees, the Auxiliary has taken care of the following:

A \$350 scholarship to University of Western Ontario School of Nursing.

Christmas trees provided for the hospital entrance, nurses' residence and War Memorial Hospital.

Furniture for the waiting room in the new x-ray department, cost \$950.

Curtains for admitting room, cost \$250.

Tea and reception following opening of the new wing for 400-500 guests.

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"Pourquoi diable," demande le médecin à son confrère, "demandez-vous toujours à vos malades la composition exacte de leurs repas?" "Parce que cela m'aide à fixer le montant de mes honoraires."

\* \* \*

Un homme, toujours satisfait de lui-même l'est peu souvent des autres; rarement on l'est de lui.



# A Nurse's Private Devotions

BEATRICE A. MACLEAN

"We are either instruments or agents of God." This arresting thought made me pause and consider my relationship to God. An instrument may serve a very useful purpose but it lacks feeling or response either for what is happening to it, or how its use may be affecting others. An agent is constantly aware of his function. He is able to enjoy the privilege of responding to the call to be an ambassador and of sharing responsibility. To qualify as a good agent, one must really believe in one's product, know it well — be sold on it.

I began to wonder about my own status. Was I an instrument or an agent of God? Very quickly I decided — I was an agent. Then I began to appraise myself. What kind of an agent was I? How effective was I? Was I sold on my product 100 per cent all of the time or just when I was with a group of enthusiastic people who shared my beliefs? How vital and important would my product be to me in the face of opposition? What would I do when others said, "Oh yes, that can be used here, here and here, but in this practical situation, forget it — it just won't work." There is no doubt that I would prefer to be a good agent. Wishing would not make me one. What must I do?

A good agent must know his product well. I must get to know God better. I knew much about Him. I knew many who testified to the fact that He had made a great success (in His terms) out of each life fully committed to Him. I had increased my knowledge about God through the Bible, and by observing His creation all around me. Still I really did not know Him. He was not a *living* God to me. I thought of Him as a rather stodgy, old, far-away Spirit. This conditioned my prayers into becoming burdensome duties — a matter of re-

citing petitions for things I could have accomplished for myself had I tried hard enough. I prayed only when I happened to have spare time, was in the mood or thought of it. I looked upon prayer as an unimportant duty with no expectation of results — altogether a pretty static affair. Was it any wonder that I had little assurance about private devotions? How could I put into words for someone else a faith which was not a living, dynamic one for me personally?

The late Professor Einstein once wrote that the problems of the world will only be solved when we have dealt with the problems of the human heart. He was right. All other problems are symptomatic of personal problems. We need to know God because we find the world has become too complex for us to handle it adequately alone. We are not self-sufficient. For a long time we have been content to busy ourselves with everything but the development of our spiritual nature. A great many of us are content to concentrate on building generations of physically healthy giants who are babes in spiritual development. The basic solution to our spiritual growth is to be found in our own private devotions. I would like to share some of the discoveries I have made in enriching and vitalizing my own devotions.

I began by reading so that I might profit by the experience of others. I wanted to see how they had handled this question. Some books I read simply to broaden my view and understanding of the world in which I lived. I sought to improve the quality of my prayers through this. Another great aid to me was attending retreats. Here I found splendid opportunity to receive spiritual instruction from those long experienced in the field. I shared in the discussion, studied the Bible, read devotional helps, and had a period of quiet time to meditate. In addition, I prayed. I was more convinced than ever that one could only learn by

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doing. If one is to learn to pray, one must practise praying.

#### PURPOSE

What was my purpose in having private devotions? I concluded that it was that I might know God and His nature, in order to have fellowship with Him as a friend. We do not make friends with the idea of using them to further our own purposes. No more should we approach God in this fashion. Primarily we want to be friends with Him so that we may enjoy His fellowship. As we grow in our knowledge of Him, we come to love Him more and more. We find that He has a purpose for each one of our lives.

#### FINDING TIME

I had to be willing to make time. I could always do this for anything I deemed really important. Rare was the occasion when I did not take time thrice daily for the meals to nourish my physical body. Was not nourishment of my spiritual nature equally important? Was I more interested in making a living than in making a life? If I was to know God, I had to consciously take time out to commune with Him.

When should I take time? This could not depend on just whether or not I was in the mood. Our God is a jealous God and makes imperious demands upon us. He insists on being put first in all things. What would happen to our clubs if we only attended meetings when we felt like it? Or to the quality of our nursing if we only attended lectures when we were in the mood? We must be equally regular in our private devotions.

We must pray daily — not because we are being good but because we need the friendship of God daily that we may live at our best. I remember a friend saying "It is when I'm wanting most to do the will of God that I feel temptation closest. In fact, the devil is sitting right there on my shoulder working overtime to lead me into temptation. The devil is not nearly so concerned over those who are indifferent to Christ's claims as he is over

those who are seeking to do the will of their Father and so be rid of his evil influence." This is one reason why we need to pray daily for God's help.

#### HOOR OF THE DAY

I found that my best time for devotions was when I was most alert. We always want to be at our best for company, when applying for a job, or when meeting someone we feel to be important. The same principle applies to our periods of private worship. The time set aside has varied. Ideally, I found that when I took time out for private devotions before breakfast, I was better equipped for whatever the day might bring.

#### PLACE

I like to have a definite and quiet spot. It helps me to concentrate more quickly. Perhaps when my prayer life has developed more richly this will seem less important to me.

#### ATTITUDE

When I expected little or nothing to happen during this period, usually little or nothing did. I discovered that if God was to become real to me, I had to be utterly sincere in my seeking. I shall always be grateful to the minister who illuminated the statement "Thou shalt not take the Lord's name in vain." Until very recently I had thought that this statement applied only to swearing. Now it has taken on a much richer meaning for me. If I am not to take His name in vain, I must not pray half-heartedly, not really meaning what I say. If I am sincere, my devotion will be a rich time of fellowship.

My chief obstacle in finding real communion with God lay in the verse of scripture to be found in St. Matthew 5:23, "So if you are offering your gift at the altar and there remember that your brother has something against you, leave your gift there before the altar and go; first, be reconciled to your brother." An unforgiving heart and unwillingness to put every area of life in God's hands can constitute a complete block to effective



prayer. We must implicitly believe in His great power, that in and through Him all things are possible.

Our approach to God should be unhurried and thoughtful. We must come before Him purposing to be obedient to the guidance He gives. This God of ours is not a wishy-washy Spirit. He demands complete obedience. We must come into His presence humbly — remembering Who He is. He is a God whose wisdom and love is so vast that it is beyond the comprehension of our finite minds. Our minds must be free of distractions with our attention centred completely on Him. I have found the Lord's prayer particularly helpful as a guide to what should be included in prayer. For a moment, let us think of it phrase by phrase. We will by no means exhaust its implications but merely touch on them.

*Our Father* — What does this personal pronoun mean? Simply that no one of us can think of ourselves as being favorites with God. He is impartial towards all of His children. He is concerned about the welfare of each regardless of what part of town, or in which part of the globe they live. *Father* implies that we are all His children, therefore we are brothers whatever our color or nationality. He amply supplies our every need. He disciplines us for our own good because He loves us. He rightly expects our love and devotion in return, for He is very much alive.

*Which art in Heaven* — Heaven is not a place for God is everywhere. Heaven is a relationship — the right relationship between God and man. Therefore He is there with me in my prayers if I fulfill my duties towards Him.

*Thy Kingdom come, Thy will be done on earth as it is in Heaven* — These phrases are coupled together because one can be accomplished only as the other is fulfilled.

*Give us this day our daily bread* — This reminds me that we are to live one day at a time.

*And forgive us our trespasses as we forgive others* — Note the condition. Think of the great number of times in our lives when we have disappointed God. Yet He is always ready to forgive. He is so gracious — we can be so

grudging with our forgiveness towards others.

It has been said that prayer should include adoration, thanksgiving, confession, petition and intercession.

*Adoration* for what He is. We adore Him because He first sought us and by His Spirit prompted us to seek Him.

*Thanksgiving* — How ungrateful we are to accept His countless blessings which have surrounded us from birth, and yet neglect to take time to so much as murmur a word of thanks to Him.

*Confession* — How the light of His presence brings to mind so many sins we would not otherwise see!

*Petition* — Recently a retreat leader described this portion of prayer as presenting God with a shopping list and expecting Him to fill it "but quick." Is God to be merely our errand boy? Do we seriously consider to Whom we are speaking and what we are asking? Is it a purely selfish request? Is it a wise request? Should we just leave it to His wisdom to decide what will be best for our ultimate and greatest good?

*Intercession* — With the knowledge that God alone can adequately supply every need of His children, we are eager to bring our friends and our enemies into His presence. I can recall including in this part of my prayer only those who were my friends or for whom I had a special concern. Suddenly one day two verses of Scripture flashed into my mind. "Love your enemies" and "If you love them that love you, what do ye more than the others? Do not even the publicans so?" Right then I started to think of the person I disliked most and sincerely asked God to bless her richly and fill her every need.

During my prayer time I like to read a portion of the Bible. I first ask God to open my eyes to the truths which lie therein, then proceed reverently, expectantly, intelligently, slowly and thoughtfully. I usually find something which arrests my attention. I close the Book and ponder on what it has to say to me. This is essentially a portion of the listening process in prayer. Too frequently we are inclined to go ahead with our own plans, (instead of first seeking God's will) and then ask His blessing for what we have attempted to do. Let us remember He will give us victory in all things



as long as we abide in Him.

I have not related this private devotion period to the nursing situation particularly. It is an individual matter and each of us has her own special needs regardless of which branch of nursing we follow. Each of us has to work out our own salvation and establish our own personal relationship with God.

What fruits can we expect from our period of private devotion? When we fulfill the conditions this period will become increasingly meaningful to our lives. We will find it absolutely in-

dispensable. We will find ourselves increasingly dependent upon His guidance and steadfast goodwill. Prayer will become more stimulating. It will cause us to grow in understanding of our Father, of the world in which we live and of ourselves. It will give us a new sense of values and a new freedom. It will give us a high purpose for living and a new zest for life. We will experience a true inner joy and peace because we are not frustrated trying to serve two masters. Rather we are agents of one Lord Who takes priority in all things.

## National Health Week

This year, Canada's 12th National Health Week, sponsored by the Health League of Canada in cooperation with Departments of Health and Education from coast to coast, will take place from January 29 to February 4.

How many of us realize the millions of dollars that are poured out on medical care — medical care for diseases *that could be prevented* each year in Canada.

A regular, paved, two-lane highway, complete with underpasses and sidewalks, could be built from Halifax to Vancouver *and back* for what Canadians pay out in medical and dental bills in *one year*. The yearly bill for dental care alone runs over the seventy-million dollar mark.

Time lost at work through illness mounts to a staggering figure — 143,150 years of working hours — or a period many times longer than all recorded history is lost in one year by Canadian workers.

Eight thousand Canadians lose their lives through accidents. Of this figure, 1,500 are

children, under the age of 15. Death comes from traffic accidents, drowning, fires, suffocation by ingested objects, accidental poisoning, falls and crushings, firearms and accidental electrocution.

Much illness and disease *can be prevented*. The enormous dental bills can be reduced by fluoridation of communal water supplies, which measure has already reduced the incidence of tooth decay by as much as 69 per cent in some areas.

The grisly yearly toll of human lives lost, and the greater number of cripples resulting from accidents, can also be lowered. Health is everybody's business — and everybody can help.

Health Week will focus attention upon two particular phases of health this year — accidents, that could be prevented, and fluoridation of communal water supplies, that has been called one of the greatest discoveries in the field of public health in the past century.

— THE HEALTH LEAGUE OF CANADA

The shortage of public health personnel is felt in most countries of the world, and nowhere so keenly as in the rural areas. It is perhaps difficult for city-dwellers to realize that over two-thirds of the world's population live in technically less developed, largely rural, areas, that their life expectancy at birth averages only 30 years, in contrast with 63 years in the more favored countries, and that their average annual per capita income is under 50 dollars.

Poverty helps to create more disease

which, in turn, tends to perpetuate poverty. It is a challenge of our times to apply properly the technical advances now available to combat such communicable diseases as typhus, yellow fever, malaria, tuberculosis, and the treponematoses, and thus bring to this large group of people an improvement in health without which they are unlikely to realize their full social, cultural and economic potentialities. It should be added that the improvement of environmental sanitation is fundamental to any advance.

— PAN AMERICAN SANITARY BUREAU

# From Little Acorns . . .

ETHELYN BUTLER

**W**E ARE GOING to trace the growth and development of a child from birth to adolescence so let us, for the sake of interest, make it a living child. To be sure, statistics are derived from living children, but let us dust off the dryness of mere statistical facts. Let us give this child not only sex but a name, weight, color and individual characteristics. Let us give him parents and a home. In a manner of speaking, we are going to watch this child through several years of growth and development so what would be more natural than that we should come to know him well and to like him.

Let us say that his parents are a young couple named Stuart who live in a small house on the outskirts of a large city. Mr. and Mrs. Stuart are college educated people who have planned for a child for several years. That is why they bought the house in the suburbs rather than going on living in their city apartment. They are keenly interested in every phase of their child's growth and development not only because they are intelligent people but because they have found that they are unable to have a child of their own and so must find one they can adopt.

The Cradle Agency has had the Stuarts' name on their list of approved parents for some time and finally they have made the happy announcement that a child of suitable background (that is, race, coloring, mental level of parents) will be born in the middle of March. If Mr. and Mrs. Stuart are willing to take the child regardless of its sex they may take it home from the hospital five days after it is born. Mr. and Mrs. Stuart really don't care at all whether the child is a boy or a girl. They even enjoy the element of surprise which is the normal condition

for prospective parents. Let us say that the great day has come. The child was born at 8:10 p.m. on March 14th. It is a boy who has been listed as "apparently normal" and entered into the newborn nursery. Mr. and Mrs. Stuart have hurried to the hospital and are standing outside of the glass partition waiting for a look at what will be, for the rest of his life, their son.

The first thing that struck Mr. and Mrs. Stuart was the realization that birth is not the beginning at all. Of course they had known this all during the time they had been gathering clothes and equipment for the baby but they were reminded more forcibly when they observed the perfection of the child's small body. They read on the card on his bassinet that his birth weight was seven pounds and eight ounces, his length was 20 inches, the circumference of his head  $13\frac{1}{2}$  inches, his chest  $12\frac{1}{2}$  inches and his crown-rump measurement  $13\frac{1}{2}$  inches. They were happy to learn that these measurements were considered quite normal. They knew that the proportions were correct because the chest measurement is supposed to be one inch less than the head measurement and the crown-rump measurement is supposed to be the same as the head measurement. The child's birth had been normal, so he lay in a rather curled up position. The doctor demonstrated to them that the baby had normal muscle tone by showing them how he resisted extension, that is, when his small arms were straightened out they immediately curled up again when released.

Mr. and Mrs. Stuart surreptitiously counted the number of fingers (and found five) when the doctor demonstrated the grasp reflex. The baby grasped fingers so tightly that the doctor was able to lift him. This was as it should be as a baby is capable of tensing his muscles only to their maximum, and having done this, cannot readily release the tension as he is only a creature of reflexes of the sim-

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Miss Butler wrote this as a student from Columbus Hospital School of Nursing, Seattle, Washington, when she was on affiliation in pediatrics at the Vancouver General Hospital.



plest sort at birth. Next the doctor showed the "walking reflex" which made Mr. Stuart think he was acquiring a Herculean child until it was explained that this is quite normal. It was, none the less, quite impressive when they saw that when the baby's body weight was supported he made walking movements with his feet.

When the baby was laid back in his bassinet the Stuarts noticed fine tremors in his little hands. They might have worried that this indicated something wrong had they not known that this is normal and caused by the incomplete development of a newborn's nervous system. The baby had about fallen asleep at this point when the doctor jarred the base of the bassinet sharply as he had another reflex to demonstrate. This was the Moro reflex, sometimes called the "startle" reflex. The baby reacted normally, shooting his arms and legs out quickly like a frog. He began crying at the same time but the doctor paid no attention to this as he wanted his examination to be quite complete. He turned the baby's head to the right and observed that when he did this the child's right arm and leg extended, and when he turned the child's head to the left his left arm and leg extended. This appeared to be quite a ridiculous bother to the baby but the Stuarts knew that the absence of this normal reaction would have indicated some defect in the baby's nervous system.

There was no decision to make about whether the Stuart's baby was to be breast fed or bottle fed so Mrs. Stuart had ready a dozen bottles made of heat resistant glass, a sterilizer with a rack for holding the bottles, nipples and nipple covers and large gripping forceps for handling the hot bottles. The doctor had already given her a formula that was quite simple. It was 8 ounces of evaporated milk, 14 ounces of water, and 2 tablespoons of sugar. She knew how to prepare the whole day's amount, at one time, using aseptic technique, and put it into six bottles. The bottles were to be covered with nipples and nipple shields and put immediately into the refrigerator. Mr. and Mrs. Stuart wanted to watch their baby being fed

so they went to the hospital and waited outside the window of the nursery.

"They're starving our baby," Mr. Stuart said, "Some of those babies are getting milk but all our baby has had is a little water!" "But he's only two days old, dear," Mrs. Stuart reminded him, "Don't you remember that the books all said that mothers' milk doesn't begin for about three days, and that it is not good for a baby to have milk before then? Anyway, that water he's getting contains 5% sugar, the doctor said. You remember that the books on infants agreed that babies are born with a calcium accumulation and that the giving of milk at too early an age might raise the baby's phosphorus level which would lower his calcium balance, which would be bad for him? You don't want him to have convulsions, do you?"

"That's right, I guess," Mr. Stuart admitted, "but it does seem heartless. See how he keeps trying to suck. Every time something touches his cheek he turns his head towards it as if he were hungry."

"Well, the impulse to suck is one of the primary ones he's born with. The nurse says that the sugar and water solution he gets will not only keep him from getting dehydrated but also give him some practice in sucking so that when he begins on formula he'll be able to take it without any difficulty. Besides that, his taking the water well will prove that there is no obstruction or abnormality which would need to be corrected before he really begins to eat. Tomorrow he'll be three days old and then we'll see some milk in his bottle."

When he was five days old Mr. and Mrs. Stuart brought their baby home and began trying to remember to call him "Joe," the name they had chosen for him, instead of "the baby." Their homecoming with Joe coincided with that of their neighbors, the Smiths, who had had a baby girl born to them on the same day that Joe was born. This was a happy coincidence as the two new mothers could look forward to companionship for their children when they were old enough to enjoy it. Besides this, they could have fun comparing their babies' growth and development.



At first it seemed that Joe's only interests in life were food and sleep. Joe's mother, who spent the most time with him, knew that he did respond to various things in his environment. She could tell that, though he couldn't really see very well, he knew the difference between light and dark as he would blink his eyes and turn away from a bright light. She knew that he enjoyed some sort of emotional pleasure while eating. She found, for instance, that when the holes in one of the nipples were too large that he could finish all his feeding in ten minutes but that this left his sucking impulse somewhat unsatisfied so that after he had eaten all he wanted he would continue to suck on whatever was near his mouth, often his fist when he could find it. His mother adjusted this so that all the nipples were made to offer enough resistance to his sucking that a feeding would take 20 minutes time to finish. When this was done Joe fell asleep after each feeding. To accomplish this Mrs. Stuart bought new nipples which did not have any holes so that she could make the holes herself with a hot, sterilized needle. She found that they were just right when they would pour milk out in a fine spray for the first moment after she tipped up the bottle and then quickly drop milk in drops. The nipples that continued to dispense milk in a spray were giving it too fast. Those that dropped milk in drops when first tipped up were dispensing it too slowly so that a baby would become too tired to suck enough to get all the milk he should have.

For a few days Joe had small blisters on his lips which were caused from sucking. At first Mrs. Stuart was afraid that the nipples she had bought were too harsh and irritating, especially when she saw that her neighbor's baby, who was breast fed did not have these. Although her books stated that this was quite normal she felt a little better when, one day, little Cora Smith developed a blister too.

When Joe's mother cleaned his nostrils with cotton-tipped applicators he opened his mouth wide to protest this indignity. When he did this his mother noticed that he had small, white spots on the midline of his hard

palate and gums. She took a clean applicator and tried to wipe them away but this could not be done so she knew that they were what the books had described as "epithelial pearls" caused by normal excess of epithelial cells. Had these spots appeared on his tongue or in the folds of his cheeks she would have known that he had thrush, and she would need to consult the doctor for treatment.

One day when Mrs. Stuart visited Mrs. Smith she observed that Cora's stools were of a different color and consistency than those of her baby. Joe's stools were a uniform, semi-firm consistency and a light tan color while those of the Smith baby were more mucoid appearing and a bright yellow color. The difference here did not indicate anything wrong with either child, but was due to the fact that one baby was formula fed and the other was breast fed.

Joe's parents had studied the graphs on normal child development so they waited for his first voluntary effort to appear when he was between two and three weeks old. His parents were satisfied when they were able to attract his attention with a brightly colored toy held for him to see. He stared fixedly at it as if fascinated.

By the time Joe was five weeks old he was quite in the habit of staring at whatever face was peering down at him. One day when he was staring at his mother he broke into his first big, unmistakable smile. She was not only glad that he was happy but was pleased that he had passed this particular milestone in his development, which should occur between the ages of four and six weeks.

When Joe was two months old he sometimes sucked his little curled up fists but when he moved his arms away from his mouth he did not know how to guide them back to it again. By the time he was three months old, however, he was able to put his fists into his mouth whenever he liked. He could not yet reach for an object though his eyes would be fastened on it longingly, but if the object, such as a rattle, were put into his hand he would wave it around happily. Joe's parents wanted their baby to develop right on schedule, but when he did, it sometimes

seemed a mixed blessing. Mr. Stuart's close-up views of Joe were myopic because the baby usually snatched off his glasses. He was six months old when he had become expert at this and his mother found it a bother too as he was equally good at putting her beads into his mouth or picking up any tiny objects, all of which he routed for digestion.

Joe weighed 18 pounds when he was six months old. He had weighed 15 pounds at four months which was right for his age according to the progress graphs. His parents knew this was right as it was double his birth weight. He was a good natured, healthy baby. He was able to reach for things with both hands or with one hand. He could pull himself to a standing position by the bars of his crib or play pen, though he was not much good at getting himself down again once he was up. He often laughed and crooned and babbled nonsense. He would reach for his mother when she came near him and seemed to play most happily when he was in the same room with her. He greeted his father each evening with happy squeals of anticipation for the rough sort of play that his mother pretended to scold about. Besides his formula he was getting quite a variety of soft strained vegetables, fruit and cereal. He had had a small amount of egg yolk. Occasionally his mother offered him milk from a cup.

Joe had been such a good baby that his mother was a bit worried when he became cross and irritable, refused his food and ran two degrees of temperature. Mrs. Stuart telephoned her doctor for advice and he suggested examining the baby's mouth for teeth. Mrs. Stuart found no teeth but there were some light colored raised areas where teeth appeared to be about to come through and his gums were generally red and swollen. During the next few weeks Joe cut four teeth. The first to appear were the lower first incisors; next came upper front incisors to match. During this time Joe's mother gave him firm rubber toys to chew on, and put away all toys made of such material as celluloid which might have broken into pieces he could swallow. Cora Smith, the

neighbor baby, was cutting teeth at this same time at about the same rate. After a few days spent with their irritable children the two mothers began snarling at their husbands. One day the fathers were caught making small bets on which child would cut the most teeth the fastest. For some reason this increased the domestic tension and tranquillity wasn't restored until the babies had been left with a sitter and the mothers taken out to dinner!

A double birthday party was held for Joe Stuart and Cora Smith but the occasion was appreciated more by the parents than the guests of honor. The babies reached for the lighted candles but were not allowed to have them. Their parents even ate their birthday cakes except for small bits which had the icing removed. The two children were put in a pen to play together but at one year they had not learned much about sharing so their playing was mostly of the "parallel" type. They observed each other closely from time to time, but mostly their direct contact was for the purpose of one taking the particular toy that the other was holding. Early in the evening the babies grew bored and fell asleep which left the parents free to get on with the main purpose of the party which was evaluation of their children's year of growth and development.

Physical development records showed that each child had tripled the birth weight, which meant that Joe weighed 22½ pounds. Each child had grown 9 inches in length, which meant that Joe was 29 inches long. Joe had 6 teeth, which is normal. Cora had 7, which Mr. and Mrs. Stuart told each other later was all right but not a bit necessary. Their motor development was such that they could pull themselves erect, and manage their arms and legs quite well. Cora Smith had been able to walk alone for two days but Joe could walk only if someone held onto at least one hand. He could stand alone, though, especially when he didn't notice that he was doing it, such as when he held some interesting object in both hands.

Personal-social development showed the good effect of a wholesome en-



vironment as the babies were happy and outgoing. Cora was a little shy but would allow herself to be picked up by a stranger if given an hour or two to study her from a distance first. Both children slept well almost anywhere, often in very awkward positions. Elimination had never been a problem. Each mother had learned her child's schedule so well that a casual sort of toilet training had been begun. At this time, this only amounted to a usually productive time spent on a child's pot in the morning. The main habit peculiarities were that Cora would not go to sleep without a particular rag doll and Joe would always crawl to the foot of his bed where he could see his mother through the doorway. Joe's mother adjusted this by moving his crib a little so that he could watch her while lying in a normal position.

Adaptive development was meager at this stage. Cora had a vocabulary of a dozen words, or so her parents claimed, but all that could be understood by outsiders was "Mamma, Dada, and ball." Joe could say only three words but everyone could understand them. They were "Mama, Dada and eat." Cora had several inches of fine, dark hair but Joe's little bald head was just beginning to show some yellow fuzz. Cora's cheeks were quite pink while Joe was cream-colored all over. Mr. and Mrs. Smith thought this indicated that Cora was healthier until they read that many babies, especially those of blonde coloring like Joe, were normally pale.

During their next year Joe and Cora played in the same yard but they didn't learn much about playing together. They appeared to entertain each other but did not work long on a community project. This could be observed in the sand box, for instance. One would watch the other shoveling sand into a pail but when given like equipment, would fling sand about independently. By the time they reached their second birthdays each child had not only front teeth but upper and lower bicusps, sometimes called "two-year molars." Cora could walk quickly and run without falling but Joe lumbered about more awkwardly. His parents believed this was because

Cora was thin and wiry while Joe was plump and sturdy. Both children ate chopped food that was usually part of the family meal rather than special baby food. Cora talked a great deal and quite plainly; Joe used only simple sentences such as "This is my truck" or "You go home." He forgot even the words he knew when Cora incited his anger, so would revert to a torrent of nonsense words, delivered with great feeling. Joe's father maintained that Cora spoke more because she was going to be a woman and was getting into practice. If he had any secret fears, he needn't have, because by the time both children were three years old they could talk equally well. In fact Joe learned two words that Cora had never heard. Had it not been for the book's recommendation against it, his mother would have washed his mouth out with soap.

One afternoon a little old lady who was collecting funds for a charity visited Mrs. Stuart as she was about to get Joe up from his nap. She introduced herself as Mrs. Gunder, explained her mission and received a contribution. A near fall over a toy on the floor brought the conversation around to children and resulted in Mrs. Gunder's staying to see Joe. After admiring him enthusiastically enough to please his mother, she asked if he resembled his father. This brought out the fact that he had come from the Cradle Agency. On hearing this Mrs. Gunder nearly choked with emotion.

"How I admire you, my dear" she said "for giving this fortunate child a home! When I think of the institutions crowded with hundreds of babies needing to be adopted my heart aches!"

"Hundreds of —" Mrs. Stuart sputtered, "It's *we* who are lucky! We were on a waiting list for four years before we got this baby! It took several years before that for us to become established well enough to even get on a waiting list. This house, our savings, my husband's job, the security of our marriage, all had to be proved before any agency would even accept our application. Don't you know there aren't enough adoptable infants to go around? In this city, this year, there



are eleven qualified couples waiting for each adoptable baby. Those who can have their own don't realize how much easier it is!" "Why I had no idea it was like that," said Mrs. Gunder disappointedly. Then, brightening, she whispered, "Are you ever going to tell him he's a-d-o-p-t-e-d?"

"Why, we've told him that since the day we got him," replied Mrs. Stuart. "Joe, who's our best little adopted boy?"

"Me," answered Joe with a wide grin.

"Oh, I know he doesn't know the meaning of the word now but by the time he does he'll be used to it and then we'll tell him how we wanted him so much that we chose him out of all others."

Mrs. Gunder was leaving and had gone as far as the front porch steps when she thought of one more possibility for drama in the situation. "How long will it be before you can tell if his blood is tainted?" she asked. Mrs. Stuart's puzzled expression made her explain, "You know, bad blood in case any of his ancestors were criminals?"

Mrs. Stuart wavered for a moment between humor and exasperation. Humor won, and she answered, "Science had made great strides in the last few years, you know. We had a sample of Joe's blood tested in a big, shiny laboratory and now we know we don't have to worry. The report told us that his blood is as pure as the driven snow. Goodbye Mrs. Grundy — I mean Mrs. Gunder." And Joe and his mother went in and shut the door.

Joe's year from two to three was fun to watch because of his rapidly expanding vocabulary and because of his attempts to imitate the adults in his life. He acted out the delivering of milk, the selling of newspapers and the departing for work with hat and brief case. His motor development showed most in his improved body balance which made it possible for him to be pushed a little without falling. He had learned to play with other children so that he would often help to make a snow man, build a fort, or pull a wagon. At his third birthday he weighed 34 pounds and was 23½ inches

tall. His toilet training was complete now except for some occasions when he was away from home. He was still friendly and happy but not quite so docile as he had been. For a while he had an almost automatic habit of saying "no" to everything, even before he knew what the request was going to be. This negative attitude was just as noticeable in Cora Smith.

Joe's and Cora's fourth birthday party was the first one they really enjoyed because they were old enough to anticipate events to some extent, and also they could enter into group games with several children. Joe weighed 37½ pounds and was 26 inches tall, which was normal for his age. His play showed more imagination now. He often insisted that he was not Joe but Dick Tracy on the trail of bandits.

By the time Joe's fifth birthday came his parents were considering buying more books so that they could look up suitable answers to his many questions. "Why" and "how" prefaced most of the things he said. Some of the questions like "how far away is the moon" and "why is ice cold" sent his parents scurrying for references. The answers to these things had to be simple and brief, though, or his attention would wander. Sometimes he interrupted an overlong explanation of something with another question. Joe's height was now 2½ inches more than the year before, and his weight was 42 pounds. His eagerness to learn things and his ability to play well with other children brought him to the right stage of development for kindergarten.

Before Joe started school at age six, he had cut two more molars behind those he had cut at age two. This did not cause the distress that his first teeth had, though he did salivate a bit more than usual. He had lost three of his deciduous teeth in front. He rather liked this process of losing teeth because each one turned into a dime when put under his pillow and, besides that, adults seemed to think his smile was more dazzling. His weight on entering school was a husky 48 pounds and he was 32 inches tall. He had, by this time, absorbed a simple sex education, as his mother was wise enough to answer his questions simply

and matter-of-factly as he asked them. At this age he often avoided his friend, Cora Smith, as he was beginning to believe that there was some sort of stigma attached to boys playing with girls. He had a few brief, transient compulsions at this time, some apparently copied from the other children at school, and some of unknown origin. Examples of these were the avoiding of all cracks in a sidewalk, scratching his ribs like a monkey, and automatically saying "what?" so that questions had to be repeated.

At age seven, even Joe's mother admitted that he was no longer a cute baby. He had grown three inches during the last year but had gained only four pounds. His baby "tummy" had disappeared and he had a long and stringy look. Two enormous teeth in his upper gums and one and a half teeth in his lower gums made his remaining baby teeth look even smaller. He regarded his teachers at school as more lofty authorities than his parents, on all things scholastic, anyway. He refused to wear any sort of clothes that were not the same as those being worn by every other boy at school.

At age eight Joe looked better to his parents. He had enough of his permanent teeth to make a more even smile now and his face had grown enough to fit them a little better. He was not so intense about school and had even decided that his parents probably had education enough to help him with his homework. He had gained another four pounds and had grown another two and a half inches.

Joe's ninth, tenth and eleventh birthdays saw no great change in him except for the normal increase in height and weight. Of course his mind developed in pace with his body so that at eleven he was in the sixth grade, was 58 inches tall and weighed 75 pounds. His neighbor Cora, was 2 inches shorter and six pounds lighter but she, too, was within the range of normal. Cora began her pre-pubertal development at this age but Joe did not begin this process until two years later.

During the years between eleven and thirteen it looked as if Cora and Joe could not possibly have been babies

born on the same day and year. She grew at the rate of 3 inches a year until she towered over Joe. She gained a total of thirty pounds without becoming at all overweight. By the time she was thirteen, even her parents were admitting that she would soon be a young lady. She imitated older girls so that she seemed even older than she was. She repaid Joe's years of neglect by scornfully referring to him as "the little boy next door."

By the time he was thirteen Joe's puberty development was most noticeably manifested by the fact that his rate of growth stepped up very sharply. When he was fifteen he was 68 inches tall, a good four inches more than Cora Smith. Cora, at fifteen, had attained all but  $\frac{1}{2}$  inch of the height she was to have as an adult, but Joe continued to grow until he was nearly eighteen. The growth after fifteen was slower, totaling only two inches.

At age fifteen Joe and Cora wondered whether they were adults or children. Most people considered them children, of course. They were still dependent upon their parents in many ways and they still had years of education ahead, but mixed with the acceptance of these facts was a restlessness and a desire to manage their own lives. Joe was bigger than his father and Cora was bigger than her mother. Each weighed less than the parent of like sex, however, as their development was not so complete as they thought. Cora and Joe became friends again at this age. They cheered each other in sports activities, associated with the same group of young people and attended the same school affairs. They never quite regained the unself-conscious relationship they had enjoyed as small children, but they didn't mind this. Once they had been small and their world had been small. Now they had grown larger physically and mentally and their world had grown larger still. Their physical development was largely, but not entirely complete. Their personal, social and adaptive development would go on all their lives. They had little idea where their growth and development would lead them or what factors would influence it, but at age 15 they were eager to get on with it.



# Nursing Profiles

During this past year, **Dorothy Lyons (Kaufman), McPhail** assumed her duties as director of the Division of Public Health Nursing with the Alberta Department of Public Health.

Born in Alberta, Mrs. McPhail received her professional training at the Hospital for Sick Children, Toronto. Securing her diploma in public health nursing and a certificate in advanced study in practical obstetrics occupied her time following graduation. She began her professional career as a district nurse with the department she now serves. Later she travelled much farther afield, spending several months with the United States Army as a civilian charge nurse in Nanking, China. Back in Canada again, Mrs. McPhail rejoined the Alberta Department of Public Health, acting at various times as assistant director of public health nursing and assistant director of health units. Interested in professional affairs, she has found time to carry out the duties of program convener with her provincial association and to serve on the entertainment committee of the Alberta Public Health Association.



*Best's Studio*

DOROTHY MCPHAIL

**Cynthia Cavell** has been appointed to the teaching staff of the University of Toronto School of Nursing where she will assist with the teaching of nursing in the basic course. A graduate in arts of the University of Toronto, she studied at the Yale University School of Nursing receiving her master's degree in nursing in 1952. After completing her professional preparation, Miss Cavell joined the nursing staff of the Yale Psychiatric Institute for a year of practical experience. A desire to study methods elsewhere lead her to Middlesex Hospital, London and later to the American Hospital of Paris before accepting her present position.

**Lucille Coté**, as director of nursing, Queen Mary Veteran's Hospital, Montreal, brings a rich background of experience to her new position. A graduate of l'Ecole des Infirmières de l'Hôpital de la Providence, Montreal, Miss Coté obtained her diploma in public health nursing from the University of Montreal and a master's degree in arts



LUCILLE COTÉ



from Columbia University. Her practical experience has been varied and enriching. As visiting nurse with the Metropolitan Life Insurance Company, she spent several years in charge of the Thetford Mines district. This was followed by administrative experience as director of the Orientation

Centre of Montreal. As assistant director of the School for Public Health Nurses, University of Montreal, she shared her knowledge of public health requirements and problems. Now her professional talents are being directed towards the field of institutional nursing.

## In Memoriam

**Agnes Arner**, a graduate of Grace Hospital, Windsor, Ont., died at Leamington, Ont., in September, 1955, following a year's illness. For ten years Miss Arner was industrial nurse for Canadian Automotive Trim at Windsor.

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**Mabel Darville**, who graduated from Royal Victoria Hospital, Montreal, in 1919, died at Vancouver on November 13, 1955, following a lengthy illness. After many years as a head nurse at R.V.H., Miss Darville was in charge of the student health service prior to her retirement.

\* \* \*

**Effie M. Feeny**, who graduated from Toronto General Hospital in 1907, died at Dearborn, Mich., on September 27, 1955. Mrs. Feeny was appointed as the first school nurse in Prince Albert, Sask., in 1913. She joined the staff of the School Hygiene Branch of the Saskatchewan Department of Education in 1918, transferring with that Branch to the Department of Public Health in 1928. She retired from her work as a public health nurse in Regina in 1935.

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**Mary Graham Gunne**, a graduate of the General Hospital, Dauphin, Man., died at Winnipeg on October 19, 1955. Miss Gunne was one of Winnipeg's first school nurses. She had also served as matron at Dauphin.

\* \* \*

**Annie Louise (Brown) Hill**, who graduated from Winnipeg General Hospital in 1901, died at Winnipeg on September 24, 1955, at the age of 79.

\* \* \*

**Ann Elizabeth Hutchison**, who graduated from the General Hospital, St. Catharines, Ont., in 1892, died at Orillia, Ont., on October 17, 1955. Miss Hutchison was superintendent of nurses at the St. Catharines hospital 1893-96. During her active career in nursing she also engaged in private duty and public health nursing service. Throughout her years of retirement

she maintained an active interest in her Alma Mater and its graduates.

\* \* \*

**Florence MacCuaig**, who graduated from the General Hospital, Cornwall, Ont., in 1922, died at Toronto on October 1, 1955.

\* \* \*

**Rita MacNeil**, who graduated from the General Hospital, Brockville, Ont., in 1936, died at Cornwall, Ont., on October 5, 1955, in her 42nd year. Miss MacNeil had practised her profession in Cornwall and district prior to her illness in 1954.

\* \* \*

**Mary C. (Hyde) McCallum**, who graduated from Toronto General Hospital in 1900, died at Toronto on October 5, 1955, at the age of 83. Mrs. McCallum's first assignment following graduation was to care for victims of a typhoid epidemic at Copper Cliff, Ont. In 1907 she became matron of the hospital at Dauphin, Man. leaving that position to be married.

\* \* \*

**Elizabeth (Jones) Miserva**, a Canadian graduate of an American Hospital who served on the staff of Royal Alexandra Hospital, Edmonton, and at Cold Lake, Alta., died at Stettler, Alta., in October 1955, after a lengthy illness.

\* \* \*

**Sister Fabian**, formerly superintendent of St. Joseph's Hospital, London, Ont., died there on October 8, 1955, at the age of 63.

\* \* \*

**Andrée Voisard**, who graduated from Royal Victoria Hospital, Montreal, in 1955, was instantly killed by the accidental discharge of a gun on October 24, 1955. She was 22 years old.

\* \* \*

**Margaret M. (Aikman) Wigginton**, who graduated from the Winnipeg General Hospital in 1929, died on August 12, 1955, following an illness of many months. At one time, Mrs Wigginton was on the staff of the Winnipeg Municipal Hospitals.

# NURSING EDUCATION

## Nursing Programs at the University of Saskatchewan

LUCY D. WILLIS, M.A.

**T**HE OPENING of the University Hospital on the campus of Saskatchewan has made possible both enlargement and diversification of the School of Nursing programs.

The basic degree program follows a pattern of two academic years, two calendar years, one academic year — in all 45 months of study spread out over four and one-half years. This basic pattern remains the same but within the framework there have been major changes. The full clinical program with the exception of tuberculosis and rural experience is now available on the campus. University faculty members direct, supervise and participate in the clinical program. It has also been possible to include a nursing science class with laboratory periods on the hospital wards during the second university year. Thus students have a gradual introduction to the clinical field and are able to make earlier applications of some of their basic science courses.

A three-year diploma program, also under the direction and supervision of the University School of Nursing, has been launched. In late August, 1954, 80 students entered this school and 75, or 95 per cent of the original group, have completed their first year. Students selected by School of Nursing faculty are admitted once a year only. They spend the first 16 weeks of their

course along with students from other Saskatchewan schools in the Centralized Lecture Program. During the next 16 weeks their time is divided between classroom lectures and demonstrations and practice in the classrooms and wards. Nursing fundamentals are taught gradually throughout this period. Considerable use is made of patient-centred situations and whenever possible these are taken directly from the students' current experiences. Other classes commonly taught in the junior period are given, such as diet therapy, pathology, pharmacology, junior medicine and surgery. Clinical practice is limited to the general medical and surgical wards. A new course, "Health as a Community Problem" has been introduced. This includes a survey of public health and social service resources, an introduction to major health problems and concludes with communicable diseases. Use is made of films, tours, projects and group work.

Basic degree course students who have already completed pathology, pharmacology, and some of the nursing fundamentals course follow a somewhat similar pattern to the above during the first 12 weeks of their program.

During the remainder of the clinical program for both groups of students the theory and clinical experience are concurrent. This is made possible by the cooperation and interest of the professors and lecturers in the clinical areas and by blocked rotations. This

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Miss Willis is assistant professor of nursing education in the School of Nursing, University of Saskatchewan, Saskatoon.





*University Hospital, Saskatoon, Sask.*

*Len Hilliard*

means that a group of students go together to a clinical service and while there have lectures and experience concurrently. All rotations and hours for students are planned by the teaching staff in cooperation with the nursing supervisors. The student follows through the usual basic experiences of medicine, surgery, obstetrics, pediatrics, operating room. Every student spends 12 weeks in psychiatry, and plans are under way for each to have six weeks of tuberculosis affiliation. Three weeks are spent in diet therapy. Here students are assigned specific experiences by the teaching dietitian. They spend one-half of their time on each of the medical and surgical services where, under the supervision of a dietitian, they learn to select and supervise the diets of patients.

In our proposed third year we are looking toward helping solve some of the problems of nursing in Saskatchewan. Our province has 121 hospitals with 50 beds or less. Many of our young graduates go out into these institutions. We hope to help them do a *better* job. Larger city hospitals and

small hospitals alike are employing nursing assistants and trained-on-the-job nursing personnel. We hope our graduates will be prepared in some measure to work with and guide such workers safely. We refer to our third year experiences as maturing ones. As we have no third year students to date we can only speak of plans. Students will return to the operating room for four weeks for further scrubbing experience and to learn the intricacies of setting up for various operations, cost and care of equipment and instruments, preparation and sterilization of packs. Some of this time will be spent in central supply service. A return of four weeks to obstetrics will concentrate on responsibility in the nursery, greater responsibility in supervision of labor, preparation for delivery, setting up the delivery room, and additional experience in teaching the mother in the care of herself and the infant. A week in the dietary department will be spent in learning about large scale ordering, supervision of the preparation of food in large quantities and menu-planning





*University Hospital Caps.*

*Fore*

*Aft*

for regular diets. Concurrent with or prior to these experiences the student will have basic lectures on principles of administration and supervision. With supervision, she will have an opportunity to be a team leader and will have a senior night or evening term and senior experience in medicine and surgery. Arrangements are being made for a four-week period in selected rural hospitals for experience in giving nursing care and learning something of the administrative relationships and responsibilities of the nurse.

These "maturing experiences" will be incorporated in the basic degree program during the latter months of

the clinical program and in a thorough and more extensive way in the final academic year. It is interesting and encouraging to note that the degree program has continued with markedly increased enrollment even after the opening of the shorter basic diploma program.

The diploma program in teaching and supervision for graduate nurses has benefited from the opening of the hospital also. To a small extent last year, and it is hoped in larger measure this year, we have had a convenient field for observation and for practice teaching during the university term.

## In the Good Old Days

*(The Canadian Nurse — JANUARY, 1916)*

For the first time in history, an army in the field is being protected against the onset of an infectious disease by inoculations. Among 20 000 of the Canadian forces there was not one case of serious trouble from the typhoid fever inoculations nor did any of the men take the disease.

\* \* \*

One of the large problems is the integration of the foreigners who have come to our country into the Canadian way of life. This is especially true in Western Canada where the women are married when very young — 13 very often — and few live to be 30. In

one district when the nurse urged that a doctor be called for a desperately sick woman, the husband said: "No, it's too much money. I can get another wife for \$5 00."

\* \* \*

The Alumnae Association of the Hospital for Sick Children has remembered its members who are serving overseas by sending a box of apples to each.

\* \* \*

The school nurses of Toronto have established a fund, on a per-cent-of-salary basis, to assist in caring for specially urgent cases of need that they find.

La réputation d'un homme est comme son ombre, qui tantôt le suit, et tantôt le pré-

cède: quelquefois elle est plus longue et quelque fois plus courte que lui.

# NURSING SERVICE

## Tuberculosis Prevention in the Far North

JOSEPHINE WALZ

I AM NOW WELL ALONG in my seventh year in northern Saskatchewan. The first four years were spent in a generalized public health program. Then, in March 1953, I was asked to initiate a tuberculosis prevention program throughout this enormous area that covers the top half of this large province.

The question that was uppermost in all our minds as the prevention program was launched was "Will there be a response?" The future course of my work hinged on the answer. It is most gratifying to report that the response has been magnificent. The people have been wonderful! Many have returned to my clinics for the second and third time. Just as soon as they learned that the object of the program was to prevent the spread of tuberculosis, they were all for it. They knew, from bitter loss, the toll that tuberculosis takes — many times wiping out whole families.

There are many difficulties to be overcome in organizing successful clinics in isolated areas where there is infrequent or no mail service. The B.C.G. vaccine, which comes all the way from Montreal, has a value-span of only five days by the time it reaches me. Since tuberculin tests must be made and read before B.C.G. is given, careful planning is necessary to reach as large a proportion of the negative

reactors as possible. There has been splendid cooperation so the survey work has not been nearly as difficult as I had thought it would be.

I fly into the larger settlements that have mail service. I make this place my headquarters for quite a large surrounding area. Then I notify the settlers over "Northern News," when I will arrive in their locality. "Northern News" is a daily radio program for the people of the north, by which we send messages and news. To these smaller settlements I travel by canoe, speed-boat, bombardière, dog-sled or walk, always with an Indian guide. At times we are accompanied by the Conservation Officer or R.C.M.P., but more often I travel alone with the guide. I never know just where I will eat or sleep, but northern hospitality has never left me standing on the dock for long. I always carry a bed-roll, in which I sleep most of the time, just occasionally in a bed. Only once did I



JOSEPHINE WALZ

Miss Walz is employed by the Saskatchewan Anti-Tuberculosis League to carry on this very effective program that she describes.

spend the night in the canoe out on the river. I took off my boots, opened up my bed-roll and stretched out under the bars, with the beaver swimming about rocking me to sleep. The guide slept on the bank — or spent the night, I should say — as he almost froze for it was October. At six in the morning we were on our way again.

Another time in May 1953, at Ile-à-La-Crosse the mail plane arrived with my B.C.G. on it. At 12:30 noon I started out for Beauval. Since it was the break-up period we had to travel with dogs, skiff and canoe. The trip was started with a dog-team, but before I could sit in the dog-sled, I had to slide down a rope off the dock to get over the open water onto solid ice. What I didn't know was that 50 three-week-old turkeys and 104 three-week-old chicks were travelling with me. They had also arrived on the mail plane from the Prince Albert hatcheries, for the R.C. mission at Beauval. But how were they to get to Beauval at this time of the year? My trip was the solution. When the ice was becoming soft, and the dogs started to fall through it, we transferred to a skiff. We travelled by skiff until we reached the Beaver River. There we transferred to speed-boat as the river was open, arriving in Beauval at five in the afternoon, chickens and turkeys very much alive, but thirsty I am certain.

In January, 1954, I travelled by train to The Pas, Manitoba. It was extremely cold, and although the train was four hours late, our faithful bombardière driver waited. After completing arrangements for my B.C.G. pick-up, we started across the lakes for Cumberland House. This was a 45-mile trip. It almost seemed like coming home, as I had lived there for three years doing public health nursing. I spent more than a month in that area, conducting clinics in four other settlements, travelling 350 miles by bombardière across lakes and portages. The weather remained 40-50° below zero the whole time. One day the tuberculin froze solid in my brief case, while I was walking from hut to hut vaccinating the aged and the blind. I also had to walk to the settlement of Pemican Portage, a distance of three miles,

when it was 50° below. No transportation was available that day — not even dogs. To keep the B.C.G. from freezing, I put it in my ski pants pockets. By wiping my face frequently to remove the frost, I didn't even freeze my nose.

In February, 1954, I arrived in Lac La Ronge by bus. This was my headquarters for the area of Little Hills, Egg Lake, Potato River and Sucker River. Here I travelled by bombardière, and by plane where there were no bombardière trails to the settlements. One day the public health nurse of Lac La Ronge and I flew to Little Hills, a distance of 15 miles, and then walked back. There were huts all along the trail and this was the only way of conducting a clinic for this area. We did not have to be rocked to sleep that night, as we had been walking on a narrow toboggan trail all the way! Even this was soft in places, for quite frequently we passed open water on the lake.

By March I was on my way back to Prince Albert by bus. Along the way the bus driver was kind enough to wait on the roadside, while I ran to a hut in the woods to see a sick baby, for the public health nurse. The baby appeared very ill, so right there and then I decided to take it with me. By six that evening it had been admitted to hospital in Prince Albert.

Still another time in May, 1954, I flew into Fond-Du-Lac from Uranium City on a chartered Cessna, still on skis, with the break-up imminent. I hoped that five days later the plane would still be able to land. Otherwise I would have had to remain for six weeks with only a tooth-brush and the clothes I wore. I travelled as light as I could, for even now we had to land quite a distance out on the lake, then walk into the settlement through slush of water, snow and caribou hair up to our knees. The young pilot was helping me by carrying my bed-roll and brief case, my only baggage, while I had to take only myself. Even then I became winded and wanted to pause a moment to sit on the snow, but the pilot would not allow this in case the ice gave away. The bush pilot takes all responsibility until we are safe on land. The water all but ran into my



sheepskin-lined boots, and I arrived in the settlement with a ring of caribou hair on my ski pants about my knees. The natives had dumped all these hairs on the snow on the lake as they tanned the hides that winter. I managed to leave five days later on a ski equipped aircraft after a successful clinic.

In August, 1954, I went from Ile-a-La-Crosse to Canoe Lake by speed-boat. I put my bed-roll in a log cabin then ran down to the dock each morning in the rain to wash my face and brush my teeth. There I also did my laundry. My meals I had with a native family. Five days later I returned by canoe. In March 1955, I flew into South End, a settlement on Reindeer lake. Next morning it was 46° below — br-r-r! There they only have outdoor plumbing. I offer this tip to newcomers on their first experience of this type of nursing — wear your

pyjamas as underwear. It not only lessens your baggage, but it's a most convenient way to get into your bed-roll, when there is little or no privacy. It is also easier to get dressed when it is 50 below.

The only time that I am not in the north is during the freeze-up period. Although this is a very rugged life, I have enjoyed every moment of it, especially because the northerners have shown such interest, appreciation and cooperation. Were it not for this, plus the wonderful plane and radio service, it would be impossible to carry on a program of this kind. I have seen about 7,000 of the 12,000 folk I have to contact. Some of them I have seen two or three times. So great is their interest, if they suspect a member of the settlement of having tuberculosis, they bring him to me to take out to the sanatorium.

## The Breath of Pain

In the development of improved drugs for relieving pain, the great problem is not the devising of promising new agents, for chemists these days have no end of ingenuity. The problem is finding out whether the drugs really relieve pain. For pain is an experience as well as a sensation; people differ in the way they react to pain, probably more than in the degree to which they sense it. The effectiveness of pain-relieving drugs cannot be based on measures of tranquillity, for there are drugs that make patients tranquil without relieving pain. Nor can one rely entirely on studies with laboratory devices like the dolorimeter, which inflicts graded heat burns on experimental subjects; the pain of dolorimeter burns is not the same as natural pain.

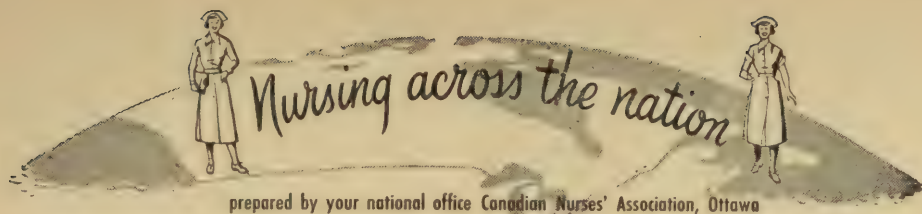
A resourceful English anesthesiologist, Dr. P. R. Bromage, has found a way out of the dilemma for one kind of natural pain at least — the severe pain occurring after operations on the chest or upper abdomen. Upper abdominal pain notoriously restricts breathing, often to the point where the patient turns blue though lying as still as he can. Dr. Bromage tests pain-relieving agents by measuring their ability to restore the patient's breathing capacity. He measures the patient's vital capacity — the volume of air he can expel after taking a deep breath — before operation to provide a base line. The vital capacity is measured

after operation but before administration of an analgesic, and then again after the pain-relieving agent has an opportunity to take hold.

Dr. Bromage employed the method to test demerol, methadon, xylocaine and a nerve-blocking procedure in 20 patients. The purpose was more to test the method than to test the drugs themselves. His results are nevertheless of interest.

The nerve-blocking procedure — epidural block — was much the most effective; it restored an average of 86 per cent of the breathing capacity lost through pain. Methadon restored 35.4 per cent of lost vital capacity, and xylocaine, administered intravenously, 22.8 per cent. Demerol was least effective; it restored only 13.5 per cent of pain-lost vital capacity.

The method has limitations. It is possible that upper abdominal pain can no more be equated to other kinds of pain than can the pain of dolorimeter burns. There are, for example, situations where demerol and xylocaine have advantages over methadon, though this test shows methadon to be a most potent analgesic drug. However, Dr. Bromage's procedure comes close to achieving true objectivity in measuring pain relief. For observation indicates that even tranquilized patients will not breathe deeply if it hurts. Patients will breathe deeply only when it really doesn't hurt.



## **To Serve**

In the field of nursing, books may be written, research projects developed, outstanding contributions recognized, but behind it all lies the word "service." The events chronicled in books recount the activities, both amusing and moving, in nursing service. Study and research in the field of nursing aim at the improvement of the service rendered to mankind. But the recognition of outstanding contributions to the improvement of the general welfare of others brings to mind the devotedness and unselfishness of the nurse in the cause of humanity, be it in the large modern hospital or on the frontiers of our far flung country.

## **Katherine Brandon is Remembered**

We read with pride in the press clippings of an impressive ceremony which took place, late in October, at the Indian reservation at Morley, Alberta, near the foot of the Rocky Mountains.

Indian school children, proud chiefs and government officials paid tribute to a Canadian nurse. Honoring Katherine Brandon, former supervisor of nurses for the Department of Indian Health Services, a cairn, built by the Indians at their personal expense, was unveiled in remembrance of her dedicated service.

Miss Brandon, whose death from polio occurred two years ago, had rendered untiring service to the Indian population which won her the love and respect of more than 700 persons living in the foothills settlement. Heartfelt tribute was expressed in the words of Chief Walking Buffalo "Our hearts are pouring out with remembrance of her."

## **Helen McArthur Returns**



*In Korea as coordinator with the International Red Cross since July, 1954, Miss McArthur returned to Canada last month. Miss McArthur is immediate past president of the C.N.A.*

## **Projects in the Atlantic Provinces**

Miss Pauline Laracy, executive secretary of the Association of Registered Nurses of Newfoundland, has been sending us some interesting information about changes in two of their schools of nursing. In the fall of 1955 extensive curriculum changes were made so that the traditional three year program could be revised to allow a one year internship after a concentrated two year educational program. It was felt that such a program would have greater educational value, would be more attractive to prospective students of nursing, would help to stabilize nursing staff and, above all, would improve patient care. In setting



up the new curriculum the content was selected on the basis of its importance in helping the student to meet the needs of the people she is to serve and to adjust to the changing demands of the practice of nursing.

From New Brunswick comes word that Miss E. Kathleen Russell is well into her project of evaluating nursing education in that province. From this evaluation will come recommendations regarding future policy. In this, the second month of a full year project, it is too early to have any indication of what the results may be. However, all nursing education waits with anticipation the publication of reports. Besides the influence the project may have on nursing in general, it is of interest to us in that it is the first piece of research in nursing education financed by a Dominion-Provincial health grant.

### ***Lamp of the Wilderness***

In a recent issue of *News of Red Cross* we find that there is a new book written by yet another Canadian nurse. The book was written under the pen name of June Spencer but the author is Mrs. J. Osinger R.N. A graduate of Toronto East General Hospital, the author is now on the staff at King's Daughters' Hospital, Duncan, B.C. "Lamp of Wilderness" describes the varied experiences of two years' nursing service at a Canadian Red Cross Outpost Hospital in an isolated district of the Cariboo.

### ***Nursing Educators Meet***

The second course on the "Integration of Civil Defence Nursing into the Basic Curriculum" was held in October at the Civil Defence College, Arnprior. Sixty-four nurses from across Canada, active in nursing education, attended. Following a week of lectures and demonstrations, the last day was set aside for the nurses to discuss problems relating to the topic. A panel of four nurses first discussed the additional responsibilities and functions that would fall to nurses in a mass disaster, the special attitudes, skills and knowledge which the nurse must acquire and the implication of these in planning the basic curriculum.

Small group discussions followed the panel discussion.

It was recognized that the principles underlying good nursing care would be the same in disaster or emergency nursing. It is important that all nurses know and understand the basic principles and be able to apply these and adjust their practice to meet varying situations. It seemed generally accepted that civil defence nursing could be integrated throughout the curriculum. Some examples discussed were:

The care of psychiatric casualties occurring in mass disaster. This can be integrated by helping the student recognize stress situations of varying degrees present in each individual patient and by giving students guidance in interpersonal relations throughout their basic course.

The care of patients with radiation sickness can start early in the student's science course. An understanding of radioactive materials can be given and continued in the nursing care of patients having radiation therapy with emphasis on the effects of radiation in atomic warfare.

Principles of decontamination are the same as those underlying the nursing care of patients with communicable diseases and the special techniques used in Civil Defence may be taught at the same time.

The heavy responsibilities and additional functions which a nurse would have to assume in a mass disaster such as atomic warfare were brought out frequently in the lectures and discussions during the week. It is important that we emphasize the necessity of helping the student develop into a mature, professional person who will react well in emergency situations. Special effort should be made to provide learning experiences and to utilize teaching methods which will help the student develop skill in human relationships, in leadership, in teaching and in acquiring the ability to evaluate a situation, to use good judgment, and to act in a purposeful manner.

Nurses should be aware of and be active in the total planning for civil defence, particularly in hospital disaster planning. The need for finding ways of improving our communica-



tions in all nursing relationships was also stressed. The nursing service administrator's responsibility in emergency disaster planning was clarified. She must know the total plan of civil defence on the national, provincial and local levels; be prepared to fit into the overall plan; and stimulate an interest in hospital disaster institutes.

The duties and responsibilities of nursing service personnel should be clearly defined and a continuous education and planning program maintained.

### *T.V. Comes to Annual Meeting*

October 19-20, 1955, marked the 39th annual meeting of the New

Brunswick Association of Registered Nurses. The sessions were held at Hôtel Dieu de L'Assomption Hospital in Moncton. In an impressive ceremony Miss Alma Law, for many years secretary-registrar of the N.B.A.R.N., was given the first honorary life membership. The citation was read by Miss Marion Myers, director of nursing, Tuberculosis Hospital, East Saint John, and the presentation was made by the president, Miss Grace Stevens.

The ceremony was televised and later viewed with great interest by all New Brunswickers. Is this unique in the annals of provincial annual meetings? It seemed to us that it was. Congratulations to New Brunswick in this successful effort.

## *Le Nursing à travers le pays*

### *Servir*

Le nursing, dans tout son ensemble, repose sur ce terme. On peut, dans ce domaine, écrire des volumes, exécuter des programmes de recherches, apporter la contribution de tout son talent; servir, reste toujours le principe fondamental de toute cette activité. Des faits, parfois amusants, parfois touchants, de la profession d'infirmières, sont relatés dans les livres et revues. L'étude et la recherche ont pour objet l'amélioration des services rendus à l'humanité mais une conception nette de tout ce qui peut être accompli pour améliorer le bien-être général, le sort de l'humanité, voilà ce qui inspire au coeur de l'infirmière le dévouement et l'oubli de soi pour soulager et pour consoler les autres que cela se passe dans un grand hôpital moderne ou sur les frontières les plus reculées de notre pays.

### *Commémoration du souvenir de Katherine Brandon*

Nous avons lu avec fierté dans les journaux un compte rendu de la cérémonie impressionnante qui a eu lieu, à la fin d'octobre, à la Réserve Indienne de Morley, en Alberta, au pied des Montagnes Rocheuses.

Les enfants indiens des écoles, les chefs altiers de même que les dignitaires du Gouvernement ont rendu hommage à une

infirmière canadienne en honorant la mémoire de Katherine Brandon, ancienne directrice des infirmières au Service de Santé des Indiens, par le dévoilement d'un tumulus de pierre édifié par les Indiens à leurs propres frais, en souvenir de ses services dévoués.

Mlle Brandon, morte de la polio il y a deux ans, a rendu à la population indienne d'inappréciables services qui lui ont valu l'amour et le respect de plus de 700 personnes vivant dans ce vallon. Le Chef Indien a exprimé du fond de son coeur les sentiments de la bourgade, dans ces mots: "Nos coeurs débordent de son souvenir."

### *Projets des Provinces de l'Atlantique*

Mlle Pauline Laracy, secrétaire-registraire de l'Association des Infirmières enregistrées de Terre-Neuve nous a communiqué des renseignements intéressants au sujet de changements apportés dans deux de leurs écoles d'infirmières. À l'automne 1955, le programme d'études fut considérablement modifié, de façon à permettre que le cours comprenne désormais deux années d'études intensives suivies d'une année d'internat. L'on a cru qu'un tel programme aurait une plus grande valeur éducative et serait plus attrayant aux futures étudiantes en nursing puis, qu'il aiderait à stabiliser le personnel infirmier et contribuera, par-dessus tout, à

l'amélioration du soin des malades. L'élaboration du nouveau programme a été basée sur l'importance de préparer l'étudiante à répondre aux besoins de la population qu'elle est appelée à servir puis à s'adapter aux exigences changeantes de l'exercice de la profession d'infirmière.

Du Nouveau-Brunswick nous arrive la nouvelle que Mlle E. Kathleen Russell a mis à exécution son projet d'évaluation de l'enseignement du nursing dans cette province. De cette analyse émergeront des recommandations au sujet de la politique future. Il va sans dire qu'au deuxième mois d'exécution d'un projet d'une année, il est encore trop tôt pour tirer des conclusions; on attend cependant avec impatience la publication des premiers rapports. A part l'influence que ce projet peut exercer sur le nursing en général, il est intéressant de noter que se sont là les premiers travaux de recherche sur l'éducation en nursing, financés au moyen d'un octroi fédéral-provincial.

### *Lamp of the Wilderness*

C'est le titre d'un ouvrage récemment publié par une autre infirmière canadienne, sous le nom de plume "June Spencer" mais dont le nom véritable est Mme J. Osinger, R.N., diplômée de Toronto East General Hospital. Cet ouvrage décrit les expériences variées d'un service de deux années dans un hôpital d'avant-poste de la Croix-Rouge, dans un district isolé de Caribou.

### *Les éducatrices en nursing se réunissent*

Le second cours sur "l'intégration du nursing de la Défense civile dans le cours de base" eut lieu au Collège de la Défense Civile à Arnprior, auquel assistèrent 64 infirmières engagées dans l'enseignement du nursing et venues de toutes les parties du Canada. Après une semaine de conférences et de démonstrations, l'on consacra une journée à la discussion de problèmes se rapportant à ce sujet. Un groupe de quatre infirmières traita premièrement des responsabilités et les fonctions supplémentaires qui incomberaient à l'infirmière dans le cas d'un désastre massif, les différentes manières d'agir, les connaissances pratiques à acquérir et leur introduction dans le programme de base. Des discussions de groupes suivirent la discussion générale.

On conclut que les principes fondamentaux d'un bon service de nursing devaient

être aussi appliqués en cas de désastre ou d'urgence. Il est donc important que toutes les infirmières connaissent et comprennent les principes de base du nursing et puissent, au besoin, les appliquer et les adapter aux différentes situations. On fut généralement d'avis que l'enseignement des soins en cas de défense civile pourrait être intégré au programme d'études. Les quelques exemples suivants furent présentés:

Le soin de cas de psychiatrie pouvant survenir au cours d'un désastre massif. Cet enseignement peut être intégré en aidant l'étudiante à reconnaître, en différentes situations, le degré de tension nerveuse de chaque individu et en la guidant, dans le domaine des relations humaines, pendant toute durée de son cours d'infirmière.

Le soin des maladies causées par radiations peut être enseigné dès le début du cours de sciences en inculquant à l'étudiante la connaissance des matières radio-actives; cet enseignement pourra ensuite être continué lors du soin de malades devant être soumis à la radio-thérapie, insistant sur les effets de la radiation dans la guerre atomique.

Les principes de la décontamination sont les mêmes que ceux que l'on applique au soin des contagieux et les techniques particulières employées dans la défense civile peuvent être enseignées en même temps.

Les lourdes responsabilités et les tâches supplémentaires qu'une infirmière est forcée d'assumer, en temps de désastre, comme pourrait par exemple en causer une guerre atomique, furent représentées à maintes reprises dans les conférences et les discussions qui eurent lieu au cours de la semaine. Il est important d'appuyer sur la nécessité d'aider l'étudiante à devenir une personne professionnelle sérieuse qui saura agir correctement en face d'une situation urgente. On s'efforcera de lui faire acquérir des connaissances pratiques utiles, d'employer des méthodes d'enseignement qui aideront à développer chez l'étudiante l'habileté et la dextérité requises dans les relations humaines, dans la façon de conduire, d'enseigner et dans la manière d'analyser une situation, agir avec discernement et de façon pratique, en toute circonstance.

Les infirmières devraient être au courant de l'organisation de la défense civile et y participer activement, particulièrement en ce qui concerne le programme hospitalier. L'on souligna aussi la nécessité qui s'impose de trouver les moyens d'améliorer nos communications dans toutes les relations du

nursing. Les responsabilités de la direction du service de nursing en cas de désastre furent précisées. Elle doit être au courant du programme de la défense civile à l'échelon national, provincial et local; être prête à occuper la place qui l'attend dans le plan général; elle doit de plus favoriser la tenue de conférences à ce sujet, à l'hôpital.

Les devoirs et les responsabilités du personnel infirmier devront être clairement définis et un programme d'enseignement et d'organisation maintenu.

### *La Télévision à l'Assemblée annuelle*

Les 19 et 20 octobre 1955 ont marqué la 39ième assemblée annuelle de l'Association des Infirmières enregistrées du Nouveau-Brunswick, dont les séances eurent lieu

à l'Hôtel-Dieu de l'Assomption, à Moncton. Au cours d'une cérémonie imposante, le titre de membre honoraire fut accordé à Mlle Alma Law, secrétaire-registraire de l'Association des Infirmières enregistrées du Nouveau-Brunswick depuis plusieurs années; c'était la première fois qu'un tel titre était conféré. La citation fut lue par Mlle Marion Myers, directrice des infirmières de l'Hôpital des Tuberculeux, Saint-Jean, et la présentation fut faite par Mlle Grace Stevens, présidente.

La cérémonie fut télévisée et suivie, par la suite, avec intérêt par tout la population du Nouveau-Brunswick. Est-ce là un fait unique dans les annales des réunions provinciales annuelles? Nous le croyons. Félicitations au Nouveau-Brunswick pour cette innovation.

## Annual Meeting in Prince Edward Island

THE 34TH ANNUAL MEETING of the Association of Nurses of Prince Edward Island was held in September, 1955, in Charlottetown. Sister Mary Irene, C.S.M., president, was in the chair. There was an attendance of 76 nurses.

The morning session was devoted to reception of reports from the chairmen of the various committees. Films on the beauties of the Canadian West were shown to stimulate travel to the C.N.A. biennial meeting in Winnipeg next summer. The general meeting was opened with an invocation by Rev. A. Frank MacLean, B.A., Minister of Trinity Church. Greetings from the city were extended by city councillor, Mr. Picton McCormac. The Department of Health and Welfare was represented by Health Officer, Dr. B. D. Howatt.

The theme for the annual meeting was Nursing Service. This was highlighted by a panel discussion on "The Team Concept in Nursing" under the chairmanship of Mrs. Lois MacDonald. A film strip captioned "Team Relationships in Nursing Care" was shown to point up particular areas of the discussion.

The president, in her address, reviewed the history of the Association which began in May, 1921, as the Graduate Nurses' Association of Prince Edward Island. In the 34 years which have elapsed, the membership

has grown from 12 to 893. There are now over 160 nursing students in the three schools of nursing in Prince Edward Island.

Sister Mary Irene expressed appreciation of the invaluable assistance given by Miss Jean Church, Dalhousie University, in conducting a two-day institute last summer dealing with curriculum construction. The president referred to the resignation of Miss Muriel Archibald, secretary-registrar and her replacement by Mrs. Helen Bolger. On behalf of the association, she spoke of the outstanding contribution Miss Archibald had made in helping the organization grow. Regret was expressed at losing such a valued member. A very pleasing feature of the meeting was the conferral of honorary membership in the Association of Nurses of Prince Edward Island on Miss Archibald. The only other member so honored in the past 34 years was Miss Anna Mair, retired superintendent of nurses of the Prince Edward Island Hospital.

Mrs. Bolger reported on the past years' activities of the Association with particular reference to the activities of the Council.

The guest speaker at the annual dinner was Dr. J. A. MacMillan, who talked on "Some Aspects of Health Insurance in Prince Edward Island."

HELEN L. BOLGER  
*Executive Secretary*

To be wiser than other men is to be more honest than they; and strength of mind is

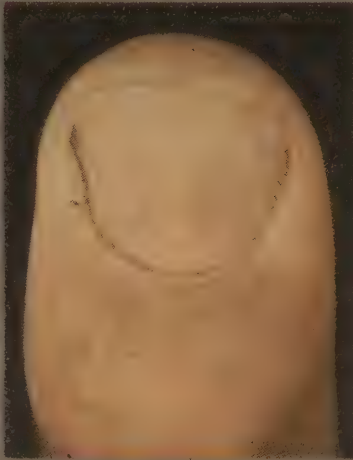
only courage to see and speak the truth.

— HAZLITT



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1. Rosenberg, S. and Oster, K. A., "Gelatine in the Treatment of Brittle Nails," *Conn. State Med. J.* 19: 171-179, March 1955.

2. Tyson, T. L., *J. Invest. Dermat.* 14:323, May 1950.

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## Les besoins de l'écolier en matière de santé

"Les exigences fondamentales de la Santé présentent trois aspects nettement différents : l'aspect physique, l'aspect social et l'aspect psychologique. C'est encore sur le plan psychologique (celui des relations humaines) que les exigences de l'individu sont le moins bien satisfaites." (O.M.S. *Rapport du Comité d'experts des soins infirmiers*).

La vérité de cette assertion semble prouvée par l'étude faite dans une école secondaire sur "Les besoins de l'écolier en matière de santé." Voici, en résumé, l'opinion de chaque membre du personnel.

Le *principal* de l'école reconnaît qu'il est de la plus grande importance que l'élève soit accepté par son groupe. L'adolescent a besoin d'un sentiment d'importance; les succès académiques et les activités extrascolaires — fêtes, réceptions, etc. — devraient fournir aux uns et aux autres une source de satisfaction. L'apparence physique a aussi son importance pour les adolescents. Les sports et le bricolage favorisent le développement de la force physique et l'intérêt qui sont nécessaires à la maturité.

Le *psychologue* énumère d'abord la sécurité (acceptation, adhésion à un groupe); ensuite la compétence (sentiment d'importance, d'impression favorable). A ces besoins s'ajoute celui qui est plus particulier aux adolescents: la liberté d'action ou le besoin d'indépendance. Les adolescents ont besoin d'une personne capable d'écouter, d'interpréter et de conseiller les jeunes de façon à leur faire prendre conscience de leurs problèmes et de leur montrer comment les résoudre et aussi comment transformer leurs erreurs antérieures en source de satisfaction pour l'avenir.

Le *psychiatre* — Ce qui caractérise l'âge de l'adolescence, c'est l'insécurité qui accompagne l'attention portée aux sexes. Il est important de créer chez l'adolescent une attitude saine à l'égard des fonctions sexuelles et ceci par une éducation adéquate. Trois facteurs importants influencent l'attitude des jeunes:

1. L'âge de la maturité et la force de l'impulsion.

2. Le degré d'emprise sur soi développée par l'individu lui-même ou due à sa formation antérieure.
3. L'existence de ressources personnelles et sociales suffisantes qui aident l'individu à s'adapter à ses émotions sans qu'elles n'évoluent en problème.

Les relations antérieures parents-enfants ont sûrement une grande importance dans l'étiologie des problèmes de l'adolescent.

La *travailleuse sociale* — Les jeux de groupe sont les favoris de cet âge. Les jeux doivent être choisis pour procurer intérêt et satisfaction et organisés en collaboration avec une personne compréhensive. Un bon programme comprend des activités mixtes (dances, réceptions) aussi bien que des activités limitées à un sexe. Le programme a pour but de fournir à l'élève l'occasion de s'exprimer, de décider, ainsi que de participer au succès du groupe.

Le *médecin* — Les problèmes de l'adolescence sont liés à la croissance et sont souvent exagérés par l'observation adulte. Les jeunes doivent être considérés comme des adolescents et non des adultes; ils ont besoin d'être éclairés au sujet de leurs problèmes qui nous paraissent sans importance mais qui sont pourtant sérieux pour eux.

Le milieu et les expériences du jeune âge peuvent avoir aidé ou nui à l'orientation de l'enfant vers l'indépendance. La compréhension et la direction pourraient compenser, dans plusieurs cas. Les adolescents manifestent de l'intérêt envers leur santé; il est bon, cependant, avec eux, de ne pas trop appuyer sur les maladies; leur enseigner les principes d'une alimentation rationnelle; la propreté méticuleuse nécessaire à la guérison de l'acné, manifestation due à la croissance; la part qu'ils peuvent prendre dans la prévention des accidents. Les échecs causent du tort à l'élève. Ils ont diverses causes: l'absence prolongée due à une maladie chronique, etc.

Les personnes qui travaillent dans le domaine de l'hygiène publique ont souvent l'occasion de venir en aide aux jeunes en voie de maturité. Elles peuvent le faire par leur compréhension de la jeunesse, par la sympathie manifestée au moment d'un problème, par la surveillance de la santé physique et mentale et par les conseils qui

Travail préparé par Mlle Monique Ranger, étudiante à l'Ecole d'Hygiène de l'Université de Montréal.

s'y rattachent, enfin, par l'éducation des parents et des adultes qui s'occupent de jeunes au point de vue étude, jeux et loisirs

ou d'autre façon, à l'occasion de visites à domicile, des cliniques, à l'industrie et à l'école.

# Hypotension

W. SCHWEISHEIMER, M.D.

**D**O YOU FEEL inexplicably tired and out of sorts much of the time? Are you frequently depressed and gloomy without knowing why? If so, you may be one of the lucky people who is assured of a long life by reason of the fact that you are afflicted with *low* blood pressure.

Hypotension is said to be present in an adult when the systolic pressure is around 100 millimeters of mercury. This may be anything from 10 to 50 millimeters less than the average or normal, depending on your age. Chronic low blood pressure, while not particularly pleasant, is a form of insurance, for statistics show that persons so affected almost never develop high blood pressure later in life.

Low blood pressure is found much less commonly than hypertension. In fact, many people are totally unaware that their blood pressure is low until they are examined by their physician, usually in the course of some routine health examination. These people feel perfectly well; they have no complaints but the feeling of tiredness, occasional headaches or weakness. It is noted most frequently in young adults, the incidence decreasing steadily with age. It is notable that the incidence is higher in women of all age groups than in men.

Blood pressure usually is lower in the morning than in the afternoon; lower during warm weather or in a warm room. Cold weather or sitting in a cold room contracts the blood vessels and increases the blood pressure. Some persons whose blood pressure is normal when they are lying down may feel weak, dizzy or they may even faint because of a sudden drop in the

pressure when they jump up quickly. This postural hypotension has no serious significance.

Blood pressure will be lower after severe bleeding due to a reduction in the volume of fluid in the closed system of the circulation. Following shock, surgery, heat stroke or any condition where the power of the heart muscle is diminished, lowering of the blood pressure is a common finding. Similarly, certain communicable diseases, notably influenza, may produce sensations of weakness, depression and fatigue for months after recovery is apparently complete, because the blood pressure remains below normal. Heavy smoking may reduce the pressure also.

The carotid sinus is a dilatation normally present in the front of the neck at the bifurcation of the common carotid artery. It is permeated by such a rich network of nerves that a blow or unusual pressure on the neck in the area of the sinus (e.g., in a boxing knockout) may cause a sharp fall in blood pressure. Similarly, wearing a tight collar may produce the same result. A 49-year-old woman went to see her physician because of episodes of dizziness, "blackouts" and frequent attacks of fainting. No apparent cause for these symptoms could be found until it was learned that they always took place when she was sitting at her dressing table. Her activities at that time consisted of the usual routines that women follow of applying creams to her face and neck for the removal of make-up. This information gave her physician the necessary clue to a correct diagnosis. She was massaging the carotid sinus with sufficient vigor to cause a marked drop in blood pressure and the resultant fainting.

Hypotension is a characteristic of Addison's disease where there is

Dr. Schweisheimer resides in Rye, N.Y.



marked adrenal cortical hypofunction. Since too little adrenalin is produced by the diseased glands, this lack results in abnormally low blood pressure. Sometimes these patients will give a reading of only 50 to 60 mm. mercury as contrasted with a normal of 120 or even the lower figure associated with essential hypotension.

What can be done about low blood pressure? Drugs such as ephedrine, or adrenal extracts by injection or by mouth, are not necessary in most cases. Stimulating beverages such as

hot tea or coffee, a cold bath, even an ample consumption of water or fruit juice will raise the blood pressure temporarily thus relieving the sensations connected with it. If no organic cause can be demonstrated by the examining physician, the individual affected should stop worrying and lead as normal an existence as possible. Only occasionally will assistance from stimulating drugs be necessary when some especially heavy demand makes an unusual strain on physical endurance.

## Book Reviews

**The Rotunda Textbook of Midwifery for Nurses**, by O'Donel Browne, M.B. et al. 302 pages. The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2, Ont. 1952. Price \$4.00.

*Reviewed by S. Monica Waters, Supervisor, Obstetrical Floor, Civic Hospital, Peterborough, Ont.*

This book is written primarily for student midwives. The concise presentation of anatomy and physiology of the female pelvis, the reproductive organs, and the development of the fetus should prove invaluable to the student in a Canadian school of nursing as well. It will be a useful reference text for the graduate nurse or instructor in the obstetrical department.

Normal labor is described. The care during labor and the technique of delivery differ somewhat from the procedures in Canadian hospitals. The treatment of complications before, during and after labor is essentially similar to that prescribed in a modern obstetrical unit in this country. Diagrams are excellent.

This is a readable book — interesting and helpful to the nurse in the obstetrical department. Student and graduate nurses should be aware that the obstetrical nurse is trained to assist the doctor. Her duties are as rewarding but differ from those of a midwife.

**University Education for Administration in Hospitals, A report of the Commission on University Education in Hospital Administration**, by James A. Hamilton, Chairman et al. 199 pages.

George Banta Publishing Co., Menasha, Wisconsin. 1954.

*Reviewed by Miss Eugenie Stuart, University of Toronto, Toronto.*

The study of University Education for Administration in Hospitals was undertaken in March 1952 by an independent commission and staff. The purpose was to question the patterns of existing programs in hospital administration and the direction of educational efforts in these programs. Criteria for future planning was to be established.

This report was presented to the representatives of the Association of University Programs in Hospital Administration in December 1953. It was given a divided reception. A number of the course representatives, while agreeing with the basic philosophy in the introductory sections of the report were in strong disagreement with many of the conclusions and recommendations. It became apparent that there were two concepts of hospital administration. One view was that it is essentially a business operation (the report refers to "the hospital industry"). The other view was that the administrator should be concerned with the broad health programs of the community and the nation, and with making the hospital an integral part of the health program.

As a prerequisite to training, the report places emphasis upon accounting and other commerce subjects, with little attention to medical sciences, sociology and the welfare aspects of patients. The recommendations as stated were: "the age limits be fixed at



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twenty-one to twenty-seven"; "the experience preference of programs be given less emphasis"; "as a condition of admission all candidates shall have completed fully and satisfactorily the basic pre-professional courses stated." The majority group in the Association of University Programs in Hospital Administration believed that if these recommendations were accepted, almost automatically professionally qualified applicants such as doctors and nurses would be largely eliminated from the course. Most promising applicants, above the age of twenty-seven would be disqualified. It would seem that the adoption of this report would be a backward step in the training of hospital administrators. It focuses too much attention on the limited business aspects and makes the administrator less qualified to take his rightful place in leadership of our overall health program development.

The Association of University Programs in Hospital Administration majority vote disassociated itself from the publication of this report.

### **Teaching Medical and Surgical Nursing**

by Jane Sherburn Bragdon, R.N. and Lillian A. Sholtis, R.N. 70 pages. J. B. Lippincott Company, Montreal and Philadelphia. 1955. Price \$2.00.

*Reviewed by Joyce B. Campkin, 3107 Douglas Road, South Burnaby, B.C.*

The experienced authors of this volume have carefully outlined a practical basic teaching plan. It stresses the modern concepts of correlated teaching.

The broader aspects of medical and surgical nursing in the outpatient department and in surgery are presented with many valuable suggestions in teaching techniques. A timely section on Disaster Nursing is included among such other topics as "Patient Teaching and Care" and "Teaching Methods and Evaluation." Consideration is given to pharmacology and diet therapy. Visual aid sources and an excellent bibliography are also included.

It would seem that the teacher using this text as a guide in her teaching program, would prepare students who have had good opportunity to learn to think of the patient as an individual. They would know the importance of early rehabilitation programs and patient as well as family teaching. They would be adept in providing good general nursing care under varied circumstances. These students would become more familiar with psychosocial problems which

accompany illness. They would be familiar with community agencies which are available to help patients and their families.

**Surgical Nursing**, by E. L. Eliason, M.D., L. K. Ferguson, M.D., and L. A. Sholtis, R.N. 754 pages. J. B. Lippincott Company, Philadelphia, Montreal. 10th Ed. 1955. \$4.75

*Reviewed by Ruth Hallam.*

In preparing this text, the authors have outlined the nursing care by basing it on the principles involved in the underlying condition. This is developed to a greater extent than in many texts written for student nurses. The nursing care follows logically when the surgical condition is understood.

A concise account is given of the disease and the surgery performed. Numerous diagrams clearly illustrate the material in the book. As a text it is easy and interesting to read. Junior students should find no difficulty in learning new material. Senior students will find it a book of value for review purposes. A large bibliography has been included at the end of most units. This serves as a source of extra information.

The text begins with a brief history of surgery and the importance of good nursing care. Factors relating to surgery such as antisepsis, asepsis, inflammation, pre-operative and post-operative care, fluid balance, special therapy, and cancer nursing are dealt with in detail. The main portion of the text is given over to surgery and its related nursing care. Each unit begins with a list of topics contained in that section and a general introduction. This gives the reader a preliminary view of the subject and its organization. More specific detail follows. The surgery of the various systems or areas is discussed individually.

New ideas and methods have been included. Some of these are freezing anesthesia, cardiac surgery, some aural surgery, and body mechanics for both patients and nurses. I found this up-to-date book a good text and recommend it for student nurses.

**Essentials of Medicine**, by Charles Phillips Emerson, Jr., A.B., M.D. and Jane Sherburn Bragdon, R.N., B.S. 922 pages. 17th ed. 1955. Price \$4.75.

*Reviewed by Florence M. Anderson, Head Nurse, Montreal General Hospital.*

This edition preserves much of the material pertaining to pathologic physiology,



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course, complications and prognosis of outstanding medical conditions included in previous editions. It introduces new diagnostic procedures and drugs. Other sections deal with therapeutics and preventative medicine.

The present trend in nursing aims to acquaint the student nurse with her patient as an individual. More emphasis is being placed on understanding the patient's physical, psychological and social needs. The authors have attempted to illustrate the importance of the entire medical team in dealing with such patient needs.

The text offers the student a substantial introduction to medical nursing. In some instances the principles underlying the outlined nursing care have been neglected or sketchily presented.

Chapter 29 is confined to tuberculosis, its pathology, occurrence, diagnosis, and nursing care. The material is detailed but explicit. Chapter 34, while short, emphasizes the potential rôle of the institutional nurse in the community. It deals with disaster nursing applicable in times of national emergency or natural disaster areas.

The book is well written and easily read. Chapter summaries offer valuable information for both study and practice. The bibliography is mainly drawn from U.S. sources but is valuable to student nurses throughout the continent. This text is recommended for student and graduate nurse reading.

**Report on the Experiment in Nursing Education of the Atkinson School of Nursing, The Toronto Western Hospital, 1950-1955**, by W. Stewart Wallace. 24 pages. University of Toronto Press, Toronto, Ont. Price \$1.00.

Another interesting and valuable piece is fitted into the mosaic of nursing education with the publication of this report of another experiment. It will be of particular help to other schools that may be contemplating the shift from the regular three-year training pattern to a concentrated two-year course in nursing education followed by one year of internship.

Several prerequisites were established before the Atkinson School of Nursing was opened: The school must have complete control of the students' time during the first two years. Nursing education and nursing service directors were to be jointly responsible for planning the experience received and supervising the student during the third year of internship. A minimum of senior matriculation was set as the pre-

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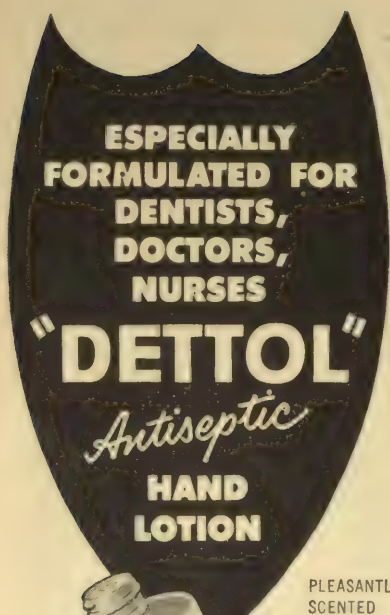
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liminary educational requirement. There would be only one class a year.

Now with the experimental period behind it, the most sanguine hopes of the administrators who planned and developed the new pattern have been amply justified. "There was no one I interviewed who was not willing to agree that the graduate of the Atkinson School of Nursing today . . . is better prepared than her predecessor prior to 1950." Enrolment in the school has increased by approximately 25 per cent. The improved standing in R.N. examinations, written at the end of the second year, must be highly gratifying.

A section of the report is devoted to costs, the key problem in the development of independent schools of nursing.

## Canadian Red Cross Society

The following are staff changes in the Quebec Division of the Canadian Red Cross Society:

**Appointments** — *Mary Wattsford* (Hosp. for Sick Children, Toronto) and *Madeleine Besner* (General Hospital, Verdun) to Barachois, Gaspé Co.

**Resignations** — *Leone Soucy* (Notre Dame Hospital) from Barachois.

## Ontario

The following are staff changes in the Ontario Public Health Services:

**Appointments** — *Mary Robbins* (Kingston Gen. Hosp., B.N.Sc. Queen's Univ.) and *Corleen Delaney* (K.G.H., B.N.Sc. Queen's Univ.), to Kingston Dept. of Health. *Margaret Kuntz* (St. Jos. Hosp., London, U. of West. Ont.), to the Separate School Board, London. *Faustina Fournier* (B.Sc., U. of Ottawa), *Norma O'Shea* (St. Jos. Hosp., Kingston, U. of Ottawa), *Catharina van Schayk* (Roman Catholic Hosp., Aalster Weg-Eindhoven, Holland, Breda University) and *Jean Wilson* (Victoria Hosp., London, U. of West. Ont.) to Ottawa B.H. *Anne Leslie* (Toronto East Hosp. U. of Toronto), from the East York-Leaside H.U. to the Scarborough Township B. H. *Kathleen Nelson* (Northampton Gen. Hosp., England, Royal Sanitary Institute) to Stormont,

Dundas and Glengarry H.U. *Arnoldina Petit* (Binnengasthuis, Amsterdam, Public Health Nursing, Tilburg, Holland) to Toronto Dept. of P.H.

**Resignations** — *Joyce (Callahan) Torrey* and *Kathleen (Alexander) Dance* from Simcoe County H.U.

## Victorian Order of Nurses

The following are staff changes in the Victorian Order of Nurses for Canada:

**Appointments** — Calgary: *Mrs. Evelyn Taylor* (Univ. of Alberta). Campbellton: *Madeleine Cormier* (Hotel Dieu Hosp., Moncton) as nurse in charge. Dartmouth: *Jean Atkinson* (Royal Vic. Hosp., Montreal). Fredericton: *Mrs. J. Brewer* (Fredericton Victoria Hosp.). North York: *Mrs. Jacqueline Bennett* (Toronto Western Hosp.). Ottawa: *Micheline Lefort* (St. Justine's Hosp., Montreal). Owen Sound: *Joyce Gillesby* (Kitchener-Waterloo Hosp.). Toronto: *Mrs. Elizabeth Collins* (Hosp. for Sick Children); *Phyllis Erskine* (Victoria Hosp., London); *Willa Flook* (Women's College Hosp.); *Betty Mickle* (Victoria Hosp., London); *Mrs. Cora Worthington* (Public Hosp., N.Z.) Windsor, Ont.: *Janet Clark* and *Mary Parkinson* (both Grace Hosp., Windsor). Winnipeg: *Mrs. Barbara Siedermann* (W.G.H.). Woodstock, N.B.: *Mrs. Kay Hamilton* (R.V.H., Montreal) as nurse in charge. Woodstock, Ont.: *Joan Ryan* (St. Mary's Hosp., Kitchener).

**Transfers** — *Mrs. Frances Cooper* from Galt to York Township staff. *Stephanie Mason* from Kitchener to Kingston. *Elizabeth MacKenzie* from Chatham, N.B. to Bathurst, N.B. as nurse in charge. *Ada McEwen* from Orillia to Edmonton as nurse in charge. *Nancy Waller* from Windsor to Montreal. *Donna Wallace* from Hamilton to Medicine Hat.

Duty: what the normal person looks forward to with distaste, does with reluctance, and boasts about forever after.

\* \* \*

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## **Planning a Gabfest?**

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## *News Notes*

### **ALBERTA**

#### **DISTRICT 3**

##### **CALGARY**

A plaque dedicated to the memory of Miss Kay Brandon was recently unveiled on the Stony Indian reserve. Miss Brandon was the first field nurse on the Stony reservation and was greatly respected by all with whom she worked. The ceremony included expressions of appreciation by Dr. W. L. Falconer, regional superintendent of Indian health services, and Chief Walking Buffalo.

A supper party in the Blue Room of the Calgary General Hospital preceded the November meeting of the Chapter. There was an attendance of 54 members. The guest speaker, Dr. A. A. Dixon chose as his topic "Your Skin and You," discussing treatment of moles, acne and hypertrichosis. During the business session it was reported that a request to have a minimum of four meetings a year had been approved. The next meeting will be held in January.

#### **DISTRICT 4**

##### **MEDICINE HAT**

A chapter meeting was held late in the fall with an attendance of 25 members. Mrs. C. R. McKay, president, was in the chair. Suggestions for the program of the 1956 annual meeting were received and forwarded to the A.A.R.N.

Mrs. A. G. Renner has been appointed corresponding member. Miss Bietsch reported on the plans being made to include matrons of small hospitals in the surrounding areas on the Committee of Nursing Education. Literature covering nurse recruitment was to be made available to try



to interest more young women in the profession.

Following the business session, a most informative film was shown on "Rheumatic Fever."

## DISTRICT 7

### EDMONTON

Miss Ada McEwen was recently appointed supervisor of the V.O.N. branch. She is a graduate of the Montreal General Hospital and studied public health nursing at McGill University.

## BRITISH COLUMBIA

### FORT GEORGE

At a recent meeting of the chapter plans were made for a bursary tea. The bursary fund is to be awarded to a high school graduate entering on a career in nursing. A successful telephone bridge has helped to augment the fund also.

Mrs. I. Ford reported on the district meeting held at Williams Lake. Mrs. M. Botsford, assistant registrar R.N.A.B.C., was the guest speaker and outlined the work in provincial administration of the nurses' association. District officers for the coming year are: pres., Mrs. F. Haggert; vice-pres., Miss G. Gowans; sec., Mrs. I. McColl; treas., Mrs. I. Ford; councillor, Mrs. M. Kalleur.

### KAMLOOPS

Looking over the activities for the past twelve months the highlight was the annual provincial meeting held in Penticton. The efforts of the local chapter were duly rewarded by a most successful meeting. The district executive was proud indeed that one of its chapters acquitted itself so admirably.

The annual meeting for 1954 was held last fall in the regatta town of Kelowna. The spring meeting was held in Kamloops where a most interesting lecture on Indian medicine was given. The northern chapter of Revelstoke was the scene of the meeting in October, while Vernon is holding the spring meeting in 1956.

The district now has over four hundred members from which the local chapters draw their ranks. Activities include raising funds for several nursing bursaries totalling over a thousand dollars yearly, equipping local hospitals and helping in the Red Cross blood donor clinics. In addition to this, members attended the travelling institute on Rehabilitation Nursing and Body Mechanics which toured B.C. in September and October. They also heard a series of special interest speakers at their own chapter meetings. In this way professional growth is maintained.

Members are looking forward to the annual provincial meeting at Nanaimo in May.

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## TRAIL

Twenty-three members were in attendance at the November chapter meeting. Plans were completed for future activities, including a Christmas party and a January ball. Miss Eidt placed a wreath in the name of the chapter on Remembrance Day. Miss Rivett and her committee reported a successful rummage sale. A volunteer to assist at the Well Baby Clinic was requested by Miss Whittington. Doctors' lectures, which form a part of the educational program for members, have been resumed and have been fairly well attended.

The guest speaker, Mrs. Frank Jones from the Kootenay Society for Handicapped Children, gave an interesting address on the work and future plans of the society.

## VANCOUVER

### *St. Paul's Hospital*

A highlight of one of the recent meetings of the alumnae association was a conducted tour through the new wing of the building. Colored slides of a European trip were shown by Dr. and Mrs. E. N. McAmmond at another meeting.

The annual home-coming was held late in the fall. A presentation of a bust of Jeanne Mance was made to the Sisters of Charity and Providence in appreciation of the work and years of service of Sister Columkille. Sr. Columkille, former director of the school of nursing, is now in North Battleford, Sask. Members of the classes of 1919 and 1920 were honored guests. Mrs. R. Whitney assisted by Mrs. G. Topping and Miss H. Hull were responsible for the success of the event.

## NEW BRUNSWICK

### MONCTON

Members of the local chapter of the N.B.A.R.N. heard several interesting reports at their regular meeting in November. L. Colwell, in her report on nursing education, announced that S. MacLeod, Moncton Hospital, and Y. Poirier, Hotel Dieu, had attended a short course in obstetrical nursing at Dalhousie University. Over 30 senior high school students accompanied by their vocational guidance counsellor were taken on a tour of Moncton Hospital. Members of the preliminary class of the same institution were presented with white testaments by the Ladies' Auxiliary of the Gideon Society. Two student nurses of the district attended the sessions of the annual provincial meeting. It was also reported that K. Russell of the Nursing Research Branch, University of N.B. had visited both local schools of nursing.

H. Hayes, president, presented the highlights of the annual meeting. A vote of thanks was extended to Miss Hayes and her committee for their part in assuring the success of the convention. Plans were made



to forward Christmas packages to a rest home for retired nurses in Edinburgh. M. Connolly was delegated to place a wreath at the Cenotaph on Remembrance Day. The report of the Local Council of Women was given by Mrs. J. Innes. At the conclusion of the business session, a program of films was enjoyed by the members.

## SAINT JOHN

A recommendation to the effect that individual nurses' fees be increased has been forwarded to the N.B.A.R.N. by the chapter. Miss L. Peters presided at the meeting in the General Hospital.

It was decided to place a wreath in the chapter's name to honor veterans on Remembrance Day. Miss W. Hoosier was named delegate to the annual provincial meeting.

## General Hospital

Miss C. M. Gleeson, supervisor of the Communicable Diseases Pavilion has retired after 33 years of service. She has taken an active interest in the work of hospital and alumnae associations and community welfare organizations. The many student nurses who trained under her guidance were instilled with her keen interest in a high level of accomplishment.

J. Kimball, J. Farnham, F. Stephenson, J. Breen have enrolled for postgraduate study at the University of Toronto. E. Corbett, D. Buchanan, A. Mahoney, and M. L. Blackford are taking postgraduate study in obstetrics at the Royal Victoria Montreal Maternity Hospital.

Recent appointments to the staff have included: D. Greive, teaching dept.; N. Wedge, S. Wright, J. Young and M. Frye, operating room; B. Nelson, asst. supervisor, male surgery. D. McQuarrie and D. McTavish recently resumed their positions as supervisors in the neurosurgery dept.

## NOVA SCOTIA

### HALIFAX

"Nursing Aspects in Rehabilitation" has been chosen as the topic of a three-day institute being held in the Arts and Administration Building, Studley Campus, Dalhousie University, March 21-23. The problem of the elderly patient will receive special consideration.

Miss Elizabeth Phillips, A.M., R.N., Executive Director, Rochester Visiting Nurse Service is to be the conference leader. She will be assisted by Mr. F. Wellard, Coordinator of Rehabilitation in Nova Scotia. Miss Phillips has had extensive experience in planning programs of care for the chronically ill and has participated in many projects related to rehabilitation nursing. "The Meaning of Rehabilitation" and "Nursing Principles and Practices in Rehabilitation" are among the subjects to be discussed.

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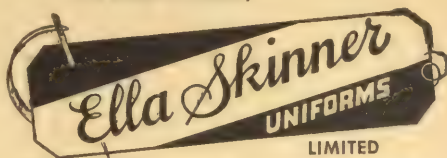


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## ONTARIO

### DISTRICT 3

#### KITCHENER

October 29 was a gala day at Kitchener-Waterloo Hospital when the Diamond Anniversary of the founding of the hospital and school of nursing was celebrated. Opened in 1895, there was accommodation for 25 patients; today there are 496 beds. Old records show that the first public ward rate was *40 cents a day!* The third annual report gives 144 patient admissions for the year. In comparison, 11,914 patients were cared for last year.

The original by-laws of the hospital contain a number of quaint rules: No patient was permitted to "retire to bed without undressing," nor could "any convalescent patient lie upon a bed in the day time without permission." Visitors required a permit from a trustee and were not allowed "to converse with patients concerning their disease or treatment."

Hundreds availed themselves of the opportunity to see all the modern features of the hospital. The climax of the day's observance was the banquet at which the Hon. Mackinnon Phillips, M.D., Minister of Health for Ontario was the guest speaker.

### DISTRICT 4

#### PORT COLBORNE

##### *General Hospital*

The appointment of Miss Helen Lauder as assistant director of nursing was announced late in 1955. A graduate of Soldiers' Memorial Hospital, Orillia, Miss Lauder formerly engaged in staff and private nursing. Later she obtained her postgraduate certificate in obstetrical nursing from Hague Maternity Hospital, Jersey City, N.J. Miss Lauder joined the staff of the General Hospital when the institution opened in 1951. Prior to accepting her present position, she served in the obstetrical department and more recently, as the medical and surgical supervisor.

### DISTRICT 5

#### TORONTO

##### *Women's College Hospital*

The class of '55 took charge of program arrangements for the November meeting of the alumnae association. Of particular interest was the address by Dr. Serreira, Jamaica. Dr. Serreira has helped organize and establish training schools for nurses in his own country. He came to Canada to study the use of Salk vaccine.

There have been several staff changes. C. E. Dixon recently retired. Mrs. Amman, L. Maurusaityte and Mrs. Gardiner have been appointed to supervisory positions. D.



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Mitobe, S. Good and P. Bryant have also joined the staff.

Members of the class of '45 held a reunion earlier this year. E. (Speer) Patrick and G. (Birchard) Grice were among those attending. Mrs. M. Gist visited the hospital before her return to Singapore. V. Treacy is stationed at a base hospital in Germany.

### DISTRICT 8

#### OTTAWA

##### *Civic Hospital*

It is of interest to graduates of her school of nursing to know that Mary J. Cullin has enrolled in the Advanced Program in Mental Health at Yale University School of Nursing. This program is in its seventh year and aims to train leaders in the nursing field to assist in the fight against mental illness. Miss Cullin recently received her degree in public health nursing from the University of North Carolina. Prior to this she was enrolled with the Roll of Midwives in England, and later served as an attache to the American Embassy in Iran. Following the completion of her Yale studies, Miss

Cullin hopes to work in the field of maternal and child health.

### PRINCE EDWARD ISLAND

#### CHARLOTTETOWN

The annual meeting of the local district of the Association of Nurses of Prince Edward Island was held in October, 1955 at the Charlottetown Hospital. Miss Ruth Ross presided.

Officers elected for the coming year are: Pres., Miss R. Ross; Vice-Pres., Sister M. Patricia; Sec., Miss F. MacLean. Executive: Misses M. MacInnis, C. Gordon, D. MacInnis, I. Dewar.

The program featured the presentation of a play "Random Harvest" under the guest direction of Miss H. Hunter. The portrayal was that of harsh treatment of a child and its effects. The cast was made up entirely of nurses.

A lively discussion followed the presentation of the play. Miss Mona Clay, Child Guidance Consultant with the Department of Health and Welfare used questionnaires to promote discussion and later summarized the results.

## QUEBEC

### MONTREAL

#### *Royal Victoria Hospital*

A most successful bazaar was held by the alumnae association in November. Mrs. A. B. Hawthorne and Miss R. Ackhurst were the conveners. The tables were in charge of Mmes. R. McKay, M. Couper, E. Butler, D. Greer, K. Dowd, Misses K. Graham, R. Ereaux, I. MacMillan, H. MacCallum. C. Grimson was in charge of the tea room and M. Clark, ticket sales. The response from the members in Montreal and in the various chapters across Canada was most gratifying. The proceeds from the bazaar, amounting to over \$2300, are being used to pay for a second edition of Dr. Edith Buchanan's textbook "A Study Guide in Nursing Arts." This is being done in recognition of the distinction which Dr. Buchanan has brought to her school of nursing.

A meeting of the Saint John chapter was held in October. L. (Rising) MacDonald was elected president and G. (Parlee) Sinclair, secretary.

P. Lawley has joined the Provincial Public Health Service, Dartmouth, N.S. A. Davies is on the staff of the Hospital for Sick Children, Toronto. C. Walkem, F. Dawson, I. Rimstead and P. Walker are attending the University of Western Ontario. L. Pepper is doing general duty in the obstetrical division of Wellesley Hospital, Toronto. G. Allen has joined the staff of the Montreal Children's Hospital. J. Henderson who resigned recently from the Moncton Hospital, has joined the staff of the Peter Bent Brigham Hospital, Boston.

There was an attendance of nine members at a recent meeting of the Moncton chapter. Mary (MacLachlan) Gillis has been elected president.

### SHERBROOKE

The first fall meeting of the district was a joint session of English and French chapters. A social evening was spent at the St. Vincent de Paul Hospital and was well attended.

#### *Sherbrooke Hospital*

The monthly meetings of the alumnae association have shown a good attendance. Plans have been made for a fall dance. One of the projects being undertaken by the members is the landscaping of the grounds around the nurses' residence. To raise funds for this purpose, a rummage sale was held in October.

## SASKATCHEWAN

### REGINA

A meeting of the local chapter, S.R.N.A. was held at the General Hospital. Discussion centered around the biennial convention in Winnipeg, in June, at which the S.R.N.A.

LOOK FOR . . .



**DURABILITY**

## EXCLUSIVE SOURCE FOR EYEREST GREEN

**THE GREY-BLUE-GREEN  
PASTEL NOW USED  
IN SO MANY O.R.'s.**

**THERE ARE MANY  
REASONS!**



## MEDICAL MICROBIOLOGY FOR NURSES

By Erwin Neter and Dorothea Edgeworth. This text emphasizes the medical aspects of microbiology, including bacteriology, virology, host resistance and immunity. 490 pages, 130 illustrations, third edition, 1954, \$5.50.

## THE ART AND SCIENCE OF NURSING

By Ella L. Rothweiler, Jean M. White and Doris A. Geitgey. Several new chapters have been added to the completely revised edition of this widely used textbook. More nursing procedures are presented than formerly. 819 pages, 180 illustrations, fifth edition, 1954, \$5.50.

**THE RYERSON PRESS  
TORONTO**



# REGISTERED HOSPITAL NURSES, PUBLIC HEALTH NURSES,

and

## Nursing Assistants or Practical Nurses

required for

### *Federal Indian Health Services*

#### **HOSPITAL POSITIONS**

Oshweken, Manitowaning, Moose Factory and Sioux Lookout, Ont.; Hodgson, Pine Falls and Norway House, Man.; Fort Qu'Appelle, North Battleford, Sask.; Edmonton, Hobbema, Gleichen, Cardston, Morley and Brocket, Alta.; Sardis, Prince Rupert and Nanaimo, B.C.

#### **PUBLIC HEALTH POSITIONS**

Outpost Nursing Stations, Health Centres and field positions in Provinces, Eastern Arctic, and North-West Territories.

#### **SALARIES**

- (1) Public Health Staff Nurses: up to \$3,300 per year depending upon qualifications and location.
- (2) Hospital Staff Nurses: up to \$3,120 per year depending upon qualifications and location.
- (3) Nursing Assistants or Practical Nurses: up to \$185 per month, depending upon qualifications.

- Room and board in hospitals — \$30 per month. Statutory holidays. Three weeks' annual leave with pay. Generous sick leave credits. Hospital-medical and superannuation plans available. Assistance may be provided to help cover cost of transportation.

- Special compensatory leave for those posted to isolated areas.

*For interesting, challenging, satisfying work, apply to:*

Indian and Northern Health Services at one of the following addresses:

- (1) 4824 Fraser St., Vancouver 10, B.C.;
- (2) Charles Camshell Indian Hospital, Edmonton, Alberta;
- (3) 10 Travellers Building, Regina, Sask.;
- (4) 522 Dominion Public Building, Winnipeg, Manitoba;
- (5) Box 292, North Bay, Ontario;
- (6) 55 "B" St. Joseph Street, Quebec, P.Q.;
- (7) Moose Factory Indian Hospital, Moosonee, Ontario.

or

Chief, Personnel Division,  
Department of National Health and Welfare,  
Ottawa, Ontario.

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ACTIVE INGREDIENTS  
Zinc Chloride - Menthol  
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In the sick room, your patients properly look to you for information and suggestions on mouth care. They will appreciate the cleansing, refreshing action of Lavoris.

DOES A THOROUGH JOB SO PLEASANTLY

will be a co-hostess. Delegates to the annual convention, M. Edwards, E. James, I. Colvin gave very informative accounts of the sessions. The officers for the coming year are: pres., M. Edwards; first vice-pres., E. Bedard; sec., I. Colvin; treas., Mrs. E. Parker. Committees: Public health, Mrs. N. Kitchen; private nursing, Mrs. C. Storey; institutional nursing, V. Ryan; registry, Mrs. M. McBrayne.

### Grey Nuns' Hospital

Five members of the staff and Sr. Papi-neau, Sr. Drouin, Sr. Moreau, Sr. LaPorte and Sr. Gauthier recently attended the Catholic Hospital Conference in Saskatoon. The sisters also were present at the annual meeting of the Saskatchewan Hospital Association.

### General Hospital

Recent appointments to the nursing staff have included: Miss Lyons, as nursing service supervisor; D. Ballantine; A. (Read) Stewart as clinical instructor in surgical nursing; E. (Kembel) Ulrich as assistant nursing arts instructor.

Late in the fall of 1954 the new wing of the nurses' residence was opened. It contains 30 single rooms, a modern teaching unit, a combined auditorium and gymnasium, rest rooms, dressing rooms, mezzanine areas and storage areas. The teaching area is made up of a large classroom with a

seating capacity of 150 which can be divided into two rooms by folding doors. There is a nursing arts demonstration room with tiered seating to accommodate 50 students, a dietetic laboratory, a library, a conference room and four offices. The entire wing has been artistically decorated and furnished.

### SASKATOON

#### City Hospital

D. Kacsmar and I. Levorson are enrolled in the teaching and supervision course at University of Saskatchewan. L. Wright is now supervisor and clinical instructor on the children's ward, while M. King is assistant nursing arts instructor.

S. MacFarlane has been appointed to replace Mrs. S. Paine as nursing arts instructor. Mrs. Paine has joined the staff of the Children's Hospital, Winnipeg.

Recent graduates who have joined the staff are: S. Cherepuschak, F. Clark, B. Hayes, A. Hompoth, D. Kindrachuk, J. McCuaig, D. Morgan, L. Morland, O. Nagy, R. Russell, M. Smith, M. St. John, E. Wright.

The September class of preclinical students were entertained at a tea at which their big sisters served. Nineteen overseas nurses are receiving their orientation to Canadian hospital practices and techniques.

Hospital building plans are going ahead steadily. The latest move was to the new obstetrical section.

"Stupéfiant!" annonce la jeune épouse à son mari. "Je viens de lire dans le journal que les femmes parlent à la cadence de

10,000 mots par jour." "J'ai toujours pensé," dit le mari, "que tu étais une femme au-dessus de la moyenne!"

# Positions Vacant

**ADVERTISING RATES** — \$5.00 for 3 lines or less; \$1.00 for each additional line.  
**U.S.A. & Foreign** — \$7.50 for 3 lines or less; \$1.50 for each additional line.

Closing date for copy and cancellations: 10th of the month preceding the month of publication. All letters should be addressed to: The Canadian Nurse, 1522 Sherbrooke St. W., Montreal 25, Que.

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**Director of Nursing & Nursing Education** for 160-bed General Hospital. Postgraduate course in administration or equivalent experience required. Salary open. Applications should give details of education, qualifications & experience. Apply Administrator, The Victoria Public Hospital, Fredericton, N.B.

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**Supervisor of Public Health Nursing** for generalized program in city of 43,000. 5-day wk., 1 mo. vacation with extra time at Christmas or Easter. Cumulative sick leave. Pension plan, Blue Cross & P.S.I., Workmen's Compensation. Transportation provided or allowance. For further information please write supplying details of training & experience to Dr. J. P. Wells, M.O.H., Peterborough, Ont.

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**Supervisor & Public Health Nurses (qualified)** for Porcupine Health Unit, 5-day wk. 4 wk. vacation. 18 days sick leave annually. Car provided. Good working conditions. Apply Secretary, Porcupine Health Unit, 164 Algonquin Blvd. E., Timmins, Ont.

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**General Supervisors, Operating Room Nurses and General Duty Nurses** for new 150-bed hospital. Starting salary for Registered General Duty Nurses \$230 with annual increases to \$40. 1½ days per mo. cumulative sick leave; 40-hr. wk; 28 days vacation; 10 statutory holidays. Apply: Supt. of Nurses, Trail-Tadanac Hospital, Trail, B.C.

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**Operating Room Supervisor, Dietitian & Staff Nurses (2).** Good salary & personnel policies. Apply Director of Nurses, General Hospital, Parry Sound, Ont.

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**Psychiatric Nurse** to assume position as Head Nurse & Clinical Supervisor of new 38-bed Psychiatric Unit in a 500-bed General Hospital. An excellent opportunity for a Psychiatric Nurse who wishes to assume leadership in developing the policies, procedures & teaching program of this new Psychiatric Unit. Patients treated only by psychiatrists. The most modern facilities & treatment methods. Cooperative administration. Bachelor's Degree required plus Psychiatric experience. Salary commensurate with experience & abilities. Write Director of Nursing, Aultman Hospital, Canton, Ohio.

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**Asst. Director of Nursing** for 200-bed hospital in Niagara Peninsula. Experienced, preferably with University certificate or postgraduate training. Good salary & personnel policies. Please furnish references stating age, qualifications & experience. Apply Director of Nursing, County General Hospital, Welland, Ont.

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**Obstetrical Clinical Instructor** for School of Nursing with capacity 195 students attached to expanding hospital of 571 beds. B.S. Degree in Nursing Education preferred or at least 3 yrs. experience & working towards degree. Located in "all American City" of 120,000 in North Eastern Ohio with educational, industrial, recreational & agricultural primary interests. Salary commensurate with qualifications. Write Director of Nursing, Aultman Hospital, Canton, Ohio.

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**Nursing Arts Instructor** for School of Nursing, with capacity 195 students, attached to expanding hospital of 571 beds. B.S. Degree in Nursing Education preferred or at least 3 yrs. experience & working toward degree. Located in "All American City" of 120,000 in North Eastern Ohio with educational, industrial, recreational & agricultural primary interests. Salary commensurate with qualifications. Write Director of Nursing, Aultman Hospital, Canton, Ohio.

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**Instructor** to teach anatomy and physiology, microbiology first term, followed by surgical nursing lectures and clinical supervision on surgical wards. Starting salary: \$255; \$10 for 2 yrs. experience; \$10 yearly increments; 1½ days sick leave, cumulative; 10 statutory holidays; 40-hr. wk; 1 class per yr. in September. Apply to: Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

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# GENERAL STAFF NURSES

## REQUIRED FOR ALL DEPARTMENTS

In new 300-bed general hospital to be opened soon



For further information apply to

**DIRECTOR OF NURSING**

## **SUDBURY MEMORIAL HOSPITAL**

**REGENT STREET SOUTH, SUDBURY, ONTARIO.**

**Head Instructor for Training School to teach Sciences.** 86-bed hospital; 30 students. Complete maintenance provided in comfortable suite. Apply, stating qualifications & salary expected, A. J. Schmiedl, Sec. Manager, General Hospital, Dauphin, Man.

**Clinical Instructor** for approved School of Nursing with University affiliation for spring 1956. Completely modern plant. Convenient Buffalo & Rochester. Starting salary: \$3,900; other conditions liberal. Apply Supt., Wyoming County Community Hospital, Warsaw, New York.

**Clinical Instructor in Pediatrics.** Modern 450-bed Hospital. Maximum of 90 Students — 1 class a yr. Excellent personnel policies. Apply Director of Nursing Education, Kitchener-Waterloo Hospital, Kitchener, Ont.

**Clinical Instructor in Obstetrical nursing** for dept. with 26-beds & **Supervisor of Nurseries** for dept. with 30 bassinets. Duties to include teaching & supervision of student nurses. University postgraduate course & experience preferred for both positions. Apply Director of Nursing, General Hospital, Oshawa, Ont.

**Public Health Nurse Grade 1.** British Columbia Civil Service, Dept. of Health & Welfare. Starting Salary \$255, \$260, \$266 per mo., depending on experience, rising to \$298. per mo. Promotional opportunities available. Qualifications: Candidate must be eligible for registration in British Columbia & have completed a University degree or Certificate course in Public Health Nursing. (Successful candidates may be required to serve in any part of the Province.) Cars are provided. 5-day wk. in most districts. Uniform allowance. Candidates must be British subjects; preference is given to ex-service women. Application forms obtainable from all Government Agencies, the Civil Service Commission, 544 Michigan St., Victoria, or 411 Dunsmuir St., Vancouver 3, to be completed & returned to the Chairman, Civil Service Commission, Victoria. Further information may be obtained from the Director, Public Health Nursing, Dept. of Health & Welfare, Parliament Bldgs., Victoria, B.C.

**Public Health Nurse.** Starting salary: \$2,844 with annual increases over 3 yrs. to \$3,228 per yr. Previous experience qualifies for a higher starting salary. Cost of transportation to Port Arthur refunded after 3 mo. Car allowance or free transportation while on duty. Pension plan after 3 yr. service. Apply stating qualifications & experience to Arthur H. Evans, Secretary, Board of Health, Port Arthur, Ont.

**Public Health Nurses** for generalized program. City of Ottawa, Health Dept. Salary: \$2,760-\$3,240 plus cost of living bonus. Good personnel policies. Superannuation & Blue Cross benefits. Apply Employment & Labor Registry Office, Room 118, Transportation Bldg., 48 Rideau St., Ottawa 2, Ont.

**Public Health Nurse** for Health Unit in south-western Ontario. Generalized program. Salary according to experience. Pension plan. 5-day wk. Generous car allowance. Group insurance. Apply Supervisor of Nursing, Elgin, St. Thomas Health Unit, City Hall, St. Thomas, Ont.

**Public Health Nurse (Qualified)** for generalized program, voluntary agency. Salary: \$2,940-\$3,712 depending on qualifications, annual increment. Student program, retirement plan, Social Security. 5-day wk., annual vacation & sick leave. Car furnished. Apply Director, Visiting Nurse Assoc., City Hall, Concord, New Hampshire.

## REGISTERED STAFF NURSES

### Required by The Provincial Government of Newfoundland Department of Health

For General Duty in small 6-32-bed hospitals. Salary commences at \$2,200 per annum on the scale \$2,200-100-2,300.

Accommodation in the hospital \$40 per mo. 24 working day vacation. Sick leave with pay. Uniforms & laundry services free. Successful applicants have their transportation paid to the hospital.

Hospitals situated in the coastal regions of the Province & act as the centre of Medical services for a group of settlements.

*For further information & application form apply:*

**Director of Nurses, Dept. of Health, St. John's, Nfld.**

**Staff Nurses for 600-bed General & Tuberculosis Hospitals with School of Nursing.** Salary: \$288-\$341. Shift, special service & educational differentials, \$10. 40-hr. wk; 3-wk. vacation; 11 holidays; accumulative sick leave. Apply Associate Director of Nursing Service, County General Hospital, Fresno, California.

**Staff Nurses & Operating Room Scrub Nurses** for 225-bed General Hospital, 20 mi. north of New York City. Salary: \$240-\$280. \$20 extra for O.R. duty & permanent evening duty; \$15 for permanent night duty. Apply Director of Nursing, St. John's Riverside Hospital, Yonkers, N.Y.

**Registered Nurses for General Duty (2)** for 76-bed fully modern hospital on C.P.R. main line & Trans-Canada Highway to Calgary & Banff. Gross Salary: \$205 per mo., perquisites \$30, \$5.00 increment every 6 mo. 1 mo. annual vacation with pay; 8-hr. day; 44-hr. wk. Sick leave with pay. Apply Matron, Municipal Hospital, Brooks, Alta.

**Registered Staff Nurses**, immediate appointments, in 511-bed newly enlarged and finely equipped general hospital. Duty assignments in medical, surgical, pediatrics, psychiatric, obstetrics, or contagion units. Northeastern Ohio stable "All-American City" of 120,000. In centre of area of recreational, industrial, and educational friendly activities. Living costs reasonable. Within pleasant driving-distance advantages of metropolitan Cleveland and Columbus, Ohio and Pittsburg, Pa. Friendly, cooperative work relations and conditions. Progressively advanced personnel policies. Starting salary: \$240 per mo. with 4 merit increases. Paid vacation, sick leave, recognized holidays, premium pay, sickness insurance and hospitalization program, retirement. Contact: Director of Personnel, Aultman Hospital, Canton, Ohio, by letter or collect telephone 4-5673.

**Registered Nurses for General Duty.** Initial salary: \$200 per mo.; with 6 or more months Psychiatric experience, \$210 per mo. Salary increase at end of 1 yr. 44-hr. wk.; 8 statutory holidays, annual vacation with pay. Living accommodation if desired. For further information apply Supt. of Nurses, Homewood Sanitarium, Guelph, Ont.

**Registered General Duty Nurses (2)** for 30-bed hospital. Salary: \$170 per mo. plus full maintenance. Salary subject to increase after 6 mos. with regular annual increase thereafter. 30 days vacation after 1 yr. service. Fully modern nurses' residence. Successful applicants reimbursed rail fare after 1 yr. New 60-bed hospital under construction. Apply, stating age & when available to the Supt. Dist. General Hospital, Dryden, Ont.

**Registered Nurses for modern 60-bed General Hospital** situated 40 mi. south of Montreal. Salary: \$200 per mo. 8-hr. duty; 44-hr. wk; rotating shifts. Many attractive benefits provided. Board & accommodation available at minimum cost in completely new motel-style nurses' residence. Apply Supt., Barrie Memorial Hospital, Ormstown, Que.

**Registered & Non-Registered Nurses, X-Ray & Lab. Technician** for General Hospital. Gross salary for nurses registered in Ont. equivalent to \$233.85 per mo. Good personnel policies, new facilities. 8-hr. rotating shifts; 44-hr. wk.; 1-day off 1 wk. & 2 the next. 1½ days holiday & sick leave per mo.; 8 legal holidays per year. Up to \$40 travelling expenses & increase paid after 1 yr. service. Semi-private Blue Cross with M.O.S. coverage. Full maintenance is provided including room, board & laundering of uniforms. Apply Supt., Lady Minto Hospital, Cochrane, Ont.

**Registered Nurses (2)** for 25-bed hospital. Salary: \$210 per mo. Full maintenance \$30. 1 mo. vacation & 3 wks., sick leave after 1 yr. service. Located in thriving town with good train & mail service. Apply Sec. Manager, Porcupine-Carragana Union Hospital, Porcupine Plain, Sask.



## GRENFELL LABRADOR MEDICAL MISSION

The Grenfell Mission operates four Hospitals & seven Nursing Stations in northern Newfoundland & on the Labrador. Here is a wonderful opportunity for valuable experience & an adventurous life. If you are making plans for next year, why not consider this splendid service still carried on in the name of a great man?

*For full information please write*

MISS DOROTHY A. PLANT, SECRETARY, GRENFELL LABRADOR MEDICAL MISSION  
48 SPARKS ST., OTTAWA 4, ONTARIO

**Registered Nurses (2).** Duties to commence as soon as possible. Salary: \$175 per mo. plus room & board. 6-day wk., 3-wk. annual vacation, statutory holidays. Situated on No. 1 Highway & Mainline C.P.R. Friendly sportsminded town. For further information apply Sec. Treas., Medical Nursing Unit, Elkhorn, Man.

**Registered Nurses** for general duty in busy 60-bed hospital in Eastern Ontario. 3-wk. vacation after 1 yr., 2-wk. sick leave, all statutory holidays. Apply Supt., Public Hospital, Smiths Falls, Ontario.

**Registered Nurses (2)** for new 30-bed hospital. Apply Matron, Creston Valley Hospital, Creston, British Columbia.

**General Duty Nurses.** Salary: \$230-270, \$10 increment for experience. 40-hr. wk. 1½ days sick leave per mo. cumulative; 10 statutory holidays, (1) mo. vacation. Must be eligible for B.C. registration. Apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

**General Duty Nurses** for 65-bed hospital. Gross salary: \$185-\$210. 44-hr. wk., statutory holidays. For further information apply Director of Nursing Services, General & Marine Hospital, Collingwood, Ont.

**General Duty Nurse (1)** for 18-bed hospital. Duties to commence Feb. 1. Salary: \$220 per mo. with \$5.00 increment every 6 mo. Board & lodging in nurses' residence \$40 per mo., 28-days annual vacation, usual statutory holidays. Apply Administrator, Lady Minto Gulf Islands Hospital, Ganges, B.C.

**General Duty Nurse** for well equipped 80-bed General Hospital in beautiful inland valley adjacent Lake Cathlyn. Boating, fishing, swimming, golfing, curling, skiing. Initial salary: \$240, full maintenance, \$40. 44-hr. wk. vacation with pay. Comfortable, attractive nurses' residence on grounds. Rail fare advanced if necessary, refunded following 1 yr. service. References required. Apply Bulkley Valley Dist. Hospital, Smithers, B.C.

**General Duty Nurses. O.R. Scrub Nurse. O.B. Supervisor** for new 143-bed plus 32-basinet hospital. Good salary & personnel policies. Apply Director of Nurses, Plummer Memorial Hospital, Sault Ste. Marie, Ontario.

**General Duty Nurses** for large General Hospital in rapidly growing industrial city. Good working conditions, modern equipment. Generous personnel policies include paid vacation, sick leave & statutory holidays. Uniforms laundered. Residence facilities available at nominal charge. Apply Dir. of Nursing, General Hospital, Hamilton, Ont.

**General Duty Nurses** for 430-bed hospital; 40-hr. wk. Statutory holidays. Salary: \$235-268. Credit for past experience. Annual increments; cumulative sick leave; 28 days annual vacation; B.C. registration required. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

**General Duty Nurses for Medical, Surgical, Pediatrics, Obstetrics.** Good salary & personnel policies. Apply Director of Nursing, Victoria Hospital, London, Ont.

**General Duty Nurses** for all departments. Gross salary: \$210 per mo. if registered in Ontario \$200 per mo. until registration has been established. \$20 per mo. bonus for evening or night duty; annual increment of \$10 per mo. for 3 yrs. 44-hr. wk., 8 statutory holidays, 21 days vacation & 14 days leave for illness with pay after 1 yr. of employment. Apply: Director of Nursing. General Hospital, Oshawa, Ont.

**General Duty Graduate Nurses** for well equipped 72-bed hospital on B.C. coast. Salary: \$222 per mo. less \$25 full maintenance. Semi-annual increments. 28 days vacation plus 10 statutory holidays after 1 yr. Transportation advanced if desired. Apply Mrs. Mark, Matron, St. George's Hospital, Alert Bay, B.C.



# OPERATING ROOM SUPERVISOR

*Applications are being received for  
Operating Room Supervisor for February 1956.*

**Postgraduate course & experience required.**

**Good personnel policies & salary.**

*For further information, write*

**DIRECTOR OF NURSING, VICTORIA HOSPITAL, LONDON.**

**General Staff Nurses** for 400-bed Medical & Surgical Sanatorium, fully approved student affiliation & postgraduate program. Full maintenance. Recreational facilities. Vacation with pay. Sick benefits after 1 yr. Blue Cross coverage. Attractive salary; 40-hr. wk. For further particulars apply Supt. of Nurses, Nova Scotia Sanatorium, Kentville, N.S.

**Graduate Nurses** for duty on Obstetrical, Medical & Surgical Wards. Personnel policies as recommended by the Assoc. of Nurses of the Prov. of Quebec. Please apply Director of Nursing, Queen Elizabeth Hospital of Montreal, 2100 Marlowe Ave., Montreal 28, Que.

**Graduate Nurses** for 100-bed West Coast General Hospital. Salary: \$250 per mo. less \$40 for board, residence, laundry. 3 annual increments; \$10 per mo. night duty bonus. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. cumulative to 36 days. Transportation allowance up to \$60 refunded after 1 yr. Apply Director of Nursing General Hospital, Prince Rupert, B.C.

**Graduate Nurses (3)** for 24-bed hospital. Salary: \$230 per mo. if B.C. registered; less \$40 board, lodging, laundry. 1 mo. vacation after 1 yr. on full pay. 1½ days sick leave per mo. cumulative. Apply, stating experience to Matron, Terrace & District Hospital, Terrace, British Columbia.

**Graduate Nurse** for 20-bed hospital. Salary: \$190 plus full maintenance. Usual holidays with pay & sick leave. Modern nurses' home. Apply Union Hospital, Vanguard, Sask.

**Baker Memorial Sanatorium, Calgary, Alberta.** offers to Graduate Nurses a 6-mo. post-graduate course in Tuberculosis. Maintenance & salary as for general staff nurses. Opportunity for permanent employment if desired. Spring & Fall Classes. Further information on request.

**Maternity Nurses for modern 60-bed General Hospital** located 40 mi. south of Montreal. Salary: \$155 per mo. 8-hr. duty; 44-hr. wk; rotating shifts. Many attractive benefits provided. Board & accommodation available at minimum cost in completely new motel-style nurses' residence. Apply Supt., Barrie Memorial Hospital, Ormstown, Que.

**Operating Room Nurses**, immediate appointments, for 511-bed newly enlarged and finely equipped hospital; 10 operating rooms now completed. Northeastern Ohio stable "All-American City" of 120,000. In centre of area of recreational, industrial and educational friendly activities; living cost reasonable. Within pleasant driving-distance advantages of metropolitan Cleveland and Columbus, Ohio, and Pittsburg, Pa. Friendly

## University of Alberta Hospital

**Edmonton, Alberta.**

Requires General Duty Nurses. Salary range: \$190-\$215 per mo. plus 2 meals & laundry. 40-hr. wk. to be instituted not later than March 31st, 1956. Rotating shifts, 21 days vacation, statutory holidays, other benefits.

*For further information apply*

**ASSOC. DIRECTOR OF NURSING (SERVICE), UNIVERSITY OF ALBERTA HOSPITAL,  
EDMONTON, ALBERTA.**

## **See Quebec With Employment Rather Than A Tourist Visit**

### **GRADUATE NURSES FOR GENERAL DUTY**

**Where?** Jeffery Hale's Hospital

**Why Unique?** Only English speaking hospital & training school in Quebec City

*For information write:*

**DIRECTOR OR NURSES, JEFFERY HALE'S HOSPITAL, 54 ST. CYRILLE ST. EAST, QUEBEC, P.Q.**

and considerate working associates and conditions. Progressively advanced personnel policies. Starting salary: \$240 per mo. with 4 merit increases. Paid vacation, sick leave, recognized holidays, premium pay, sickness insurance and hospitalization program, retirement. Contact Director of Personnel, Aultman Hospital, Canton, Ohio, by letter or collect telephone 4-5673.

**Operating Room Nurses**, preferably with experience, for 75-bed hospital. Operating unit consists of 2 theatres, emergency treatment & recovery room. Apply Supt., Carleton Memorial Hospital, Woodstock, N.B.

**Operating Room & General Staff Nurses** for 155-bed Acute General Hospital located in famed San Joaquin Valley. Starting salary: \$285 per mo., \$10 mo. additional for O.R., regularly scheduled increases. 40-hr., 5-day wk. 2 wk. paid vacation after 1 yr., 3 wk. after 5 yrs., 1 mo. after 10 yrs. Travel expenses refunded after 1 yr. employment. Apply Personnel Manager, Community Hospital, P.O. Box 1232, Fresno, California.

**Experienced Hospital Bookkeeper & Receptionist**. Excellent on collections. Would also consider **Housekeeper's** position in a hospital. January 1956. Apply Box K, The Canadian Nurse, 1522 Sherbrooke St. W., Montreal 25, Que.

**Dietitian** for 65-bed hospital. Good working conditions. Living accommodation available. For further information apply Administrator, General & Marine Hospital, Collingwood, Ont.

**Office Nurse** with commercial training required for doctor's office January 1956. Must have ability to take full responsibility for running large office practice in St. Catharines. Apply Box J, The Canadian Nurse, 1522 Sherbrooke St. W., Montreal 25, Que.

**General Duty Nurses** immediately for new 600-bed hospital expanding to 850-beds. Opportunities for promotion to **Head Nurse** or higher. Located on 128 acres in eastern suburb of Cleveland. Starting salary: \$3,060 with periodic merit increases to \$3,300 per yr. Progressive personnel policies include 40-hr. wk., straight shifts, paid vacation, holidays & sick leave. Nominal cost housing available on grounds. Licensure available through Ohio State Nurses' Board if desired, providing nurse meets requirements Hospital affiliated with Western Reserve University Medical School. Additional information available upon request. Apply Director, Personnel Relations, Highland View Hospital, Harvard Road, Cleveland 22, Ohio.

## **UNIVERSITY HOSPITAL**

**SASKATOON, SASK.**

### **Requires**

General Staff Nurses for Medical, Surgical, Obstetrical and Pediatric Services. Forty-four hour week. Salary \$210.00 to \$260.00 gross per month. Differential for evening and night duty.

*Apply to:*

**DIRECTOR OF NURSING, UNIVERSITY HOSPITAL,  
SASKATOON, SASK.**

## McKELLAR GENERAL HOSPITAL, FORT WILLIAM, ONT.

### Requires

#### CLINICAL INSTRUCTOR IN OPERATING ROOM

Gross salary commensurate with experience, 28 days vacation after one year, 8 statutory holidays, sick leave accumulative to 60 days; Residence accommodation available at reasonable rates. Hospital has recently completed a well equipped and staffed wing with extensive renovation program progressing in the old section.

### APPLY DIRECTOR OF NURSING

Applications are invited for the position of **Director of Nursing** for 30-bed General Hospital. State experience & salary required. Residence accommodation. A building program to replace the present hospital has been scheduled for 1956. Apply Administrator, General Hospital, Ladysmith, B.C.

**Graduate Registered Nurses** for floor duty for 68-bed hospital, 68 miles from Montreal. Excellent bus & train service. Salaries are in accordance with R.N.A.P.Q. Full maintenance. 8-hr. duty, rotating shift, 1½ days off per wk., 30 days annual vacation, sick leave allowance. Blue Cross hospitalization paid by hospital. Apply Supt., Brome-Missisquoi Perkins Hospital, Sweetsburg, Que.

**Matron** for very active company Hospital in rapidly expanding community. Position requires person experienced in organization & supervision of nursing, clinical & service Depts. Postgraduate training in nursing administration desirable. Apply in writing to Personnel Dept., Aluminum Co. of Canada, Ltd., Kitimat, B.C.

**General Duty Staff Nurses** for 52-bed General Hospital. Evening & night shift. Beginning salary: \$300 per mo. 40-hr. wk. Apply Director of Nursing, County General Hospital, 1375 N. Main St., Lapeer, Michigan.

**General Duty Nurses.** Jan. 15-'56 for new air-conditioned 60-bed wing. Salary: \$200 per mo., after 6-mo. \$10 increase. 3-wk. vacation, statutory holidays, sick pay. Benefits include free life insurance, pension plan, Blue Cross, free medical & surgical care. Residence available. Apply Director of Nurses, Doctor's Hospital, 28 Major St., Toronto.

**General Duty Registered Nurses** for modern 18-bed private hospital in iron mining town, 180 mi. north of Sault Ste. Marie. Starting salary: \$235 with annual increase, less \$20 for maintenance. Excellent accommodations & personnel policies. Transportation allowance after 3 mo. service. Apply Supt., Lady Dunn Hospital, Jamestown, Ont.

**Registered Nurse** for 12-bed hospital. Salary: \$250. Duties to commence as soon as possible. For full particulars phone or write Mrs. M. Broley, Sec., Community Hospital, Beechy, Sask.

**Registered Nurses (2) for Jan. '56. (3) for June '56.** for active hospital 10 mi. from Radium Hot Springs, B.C. New modern hospital & nurses' residence to be completed June '56. Salary according to R.N.A.B.C. Apply Supt. of Nurses, Bruce Memorial Hospital, Invermere, B.C.

**Assistant Head Nurses** for children's orthopedic hospital. Good personnel policies. Pension plan available. Apply Director, Shriner's Hospital for Crippled Children, 1529 Cedar Ave., Montreal.

## UNIVERSITY HOSPITAL

### Requires

#### ADMINISTRATIVE SUPERVISORS

to organize the departments of Pediatrics and Surgery in new hospital.  
Salary \$240.00 to \$300.00. Good personnel policies.

Apply to:

DIRECTOR OF NURSING, UNIVERSITY HOSPITAL,  
SASKATOON, SASK.



## CANADIAN RED CROSS SOCIETY

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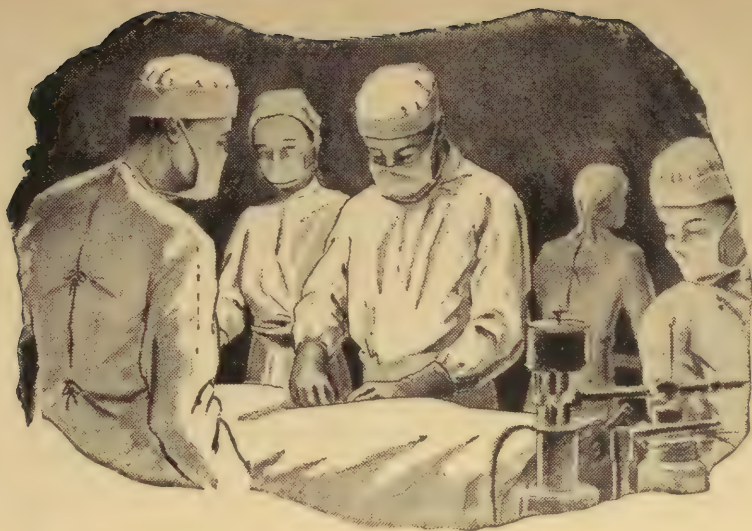
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# THE CANADIAN NURSE

## *L'Infirmière Canadienne*

VOLUME 52

NUMBER 2

FEBRUARY 1956

- 86** NEW PRODUCTS
- 93** TOO FEW FOR TOO MANY.....*A. Girard*
- 95** MENTAL HEALTH FOR NURSES.....*W. H. Cruickshank*
- 101** L'EVOLUTION DE LA CARDILOGIE  
ET SES PROBLÈMES.....*P. David*
- 107** COUNTERPANE LAND.....*L. P. Bell*
- 109** WHAT ABOUT VACATION PLANS?.....*E. A. Collins*
- 111** IN MEMORIAM
- 112** THE ROLE OF THE INDUSTRIAL NURSE  
IN ACCIDENT PREVENTION.....*T. Greville*
- 114** SCHIZOPHRENIA.....*A. Stewart*
- 120** CAVERNOUS SINUS  
THROMBOSIS.....*C. Lawton and M. Hobin*
- 122** WITH OUR TRAINING WE CAN HELP.....*E. Groenewald*
- 126** NURSING ACROSS THE NATION
- 127** LE NURSING À TRAVERS LE PAYS
- 132** SÉLECTION
- 136** BOOK REVIEWS
- 144** NEWS NOTES
- 160** OFFICIAL DIRECTORY

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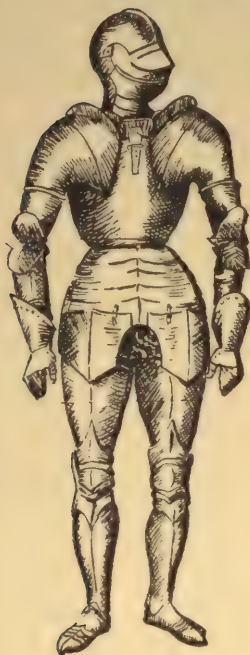
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# **BRITISH DRUG HOUSES**

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# Between Ourselves

Anticipating the theme for the 1956 convention, Chairman of the Nursing Service Committee **Alice Girard**, as our guest editor, poses some very penetrating questions. Miss Girard is keenly alert to the problems she presents for she is director of nursing at Hôpital St. Luc in Montreal. She realizes, as do directors of nursing everywhere, that there just are not enough pairs of hands available to meet the demands for nursing service in hospitals and public health organizations alike. Seeking the answers to these questions is the responsibility of every member of the profession. The Committee on Nursing Service can and does give superb leadership in the quest but 15 or 20 committee members or even 1500 or 2000 interested nurses are not enough — it is up to all of us to give our loyal assistance.

\* \* \*

One answer is being furnished by the women who are being trained in schools similar to the one described by **Emily Groenewald**. Sponsored by the Department of Veterans Affairs there are schools for nursing assistants in three centres — Toronto, Montreal and Halifax. Like the schools organized under the provincial health departments, these schools follow the pattern defined by the Canadian Nurses' Association. Thus opportunity is provided for persons who are not able to enter our schools of nursing to become qualified so that they too may swell the numbers of those who can give reality to our convention theme "Nursing Serves the Nation."

\* \* \*

Last September, **Dr. W. H. Cruickshank** gave a very thoughtful address at the convention of the Canadian Public Health Association. He took as his topic the problems of Mental Hygiene in Industry. The paper was published, as given, in the *Canadian Journal of Public Health* in December, 1955. Permission was given for us to reprint it but as we read it through, the thought recurred, again and again, of how applicable all of the points were to improving the mental health of nurses. If only we could slant the material directly to our profession! Happily, as soon as Dr. Cruickshank was approached regarding this possibility he was

completely willing to cooperate with us in this transposition of emphasis. We hope that, as and when your tensions may mount, you will turn again to Dr. Cruickshank's outline of desirable mental health activities to find guidance in relieving tension-producing situations.

\* \* \*

How can usually active children be kept entertained and occupied when accident or illness makes it necessary for them to stay in bed for a while? Children's hospitals have departments of play therapy organized to meet this need. Even in small pediatric units attention is given to keeping the not-too-sick child busy. What happens when he goes home? How about the child whose disability has not required hospitalization?

**Louise Price Bell**, out of her experience as a nurse and as a mother, gives some very practical answers to these questions in her "Counterpane Land." She points out how inexpensively the necessary materials can be procured. Every nurse, but particularly those who see the children in their homes, will find this article a most helpful supply cupboard of ideas and suggestions.

\* \* \*

How are your plans maturing for attendance at the CNA convention in Winnipeg next June? As noted in "Nursing Across the Nation," the number of pre-registrations is mounting steadily at National Office. How about your post-convention plans? That trip to Honolulu described by **Ethel Armstrong Collins** sounds pretty alluring, doesn't it? Just south of the Tropic of Cancer, the Hawaiian Islands are *never* too hot yet they are warm enough for sea and sun bathing at any time of the year.

If your heart was set on the Klondyke Gold Nugget tour, we are very sorry that you will have to be disappointed. Switch your plans and explore the eastern parts of Canada instead. Aren't you relieved to learn that others besides honeymooners do go to Niagara Falls? Be sure to visit the National Office when you are in Ottawa. The Journal office is very easy to find when you reach Montreal. On the south side of Sherbrooke Street, 1522 is just east of Guy Street. Come and see us!

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# New Products

Edited by DEAN F. N. HUGHES

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---

## NEMBU-SERPIN

**Manufacturer**—Abbott Laboratories, Ltd., Montreal.

**Description**—Each tablet contains: Nembutal (pentobarbital) calcium 30 mg.; reserpine 0.25 mg.

**Indications**—As a sedative and tranquilizer in mild anxiety states, tension, insomnia and in mild essential hypertension.

**Administration**—In mild anxiety states, etc., 1 tablet at bedtime with additional tablets during the day as indicated. Maximum daily dose 4 tablets. In mild hypertension, 1 or 2 tablets daily.

---

## PLACIDYL

**Manufacturer**—Abbott Laboratories, Ltd., Montreal.

**Description**—Each red gelatin capsule contains: Placidyl (B-chlorovinyl ethyl ethynyl carbinol) 500 mg., a nonbarbiturate hypnotic with low toxicity which does not produce initial excitation or a "hangover" effect.

**Indications**—Simple insomnia resulting from tension, mild anxiety, mild excitement or agitation.

**Administration**—Adults, 500 mg. 15 to 30 minutes before retiring. Duration of effects is 4 to 5 hours. Only mild side effects have been reported — mild depression, symptoms of mild excitation and stomach upsets occur rarely.

---

## STATIMO

**Manufacturer**—Charles E. Frosst & Co., Montreal.

**Description**—Carbazochrome salicylate complex, tablets of 2.5 mg., and ampoules of 5 mg.

**Indications**—Capillary hemorrhage.

**Administration**—Intramuscularly, 1 cc. every 2 to 4 hours until bleeding ceases; orally, after bleeding has been controlled, by injection or for initial and maintenance therapy, 1 tablet every 4 hours.

---

## VALMID

**Manufacturer**—Eli Lilly and Company (Canada) Limited, Toronto 13, Ontario.

**Description**—A short-acting nonbarbiturate sedative having a rapid onset of effect.

**Indications**—For the management of simple insomnia caused by mental unrest, excitement, fear, worry, apprehension or extreme fatigue.

**Administration**—Adults: 1 or 2 tablets 15 to 20 minutes before retiring. May be administered to patients who are hypersensitive to barbiturates.

---

## MIGRAINE TABLETS

**Manufacturer**—Organon Inc., Canadian Branch, Montreal.

**Description**—Contains: Ergotamine tartrate 1.0 mg., caffeine 100.0 mg., belladonna alkaloids levorotatory 0.1 mg. and acetophenetidin 120.0 mg.

**Indications**—For the treatment of migraine headaches.

**Administration**—Early recognition of symptoms and proper dosage are of prime importance in vascular headache therapy. A dose of 2 tablets should be taken immediately upon noticing symptoms of migraine (prodromal stage), followed by 1 tablet every 20-30 minutes until the attack aborts. No more than 6 tablets should be taken per migraine attack.

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## XYLOCAINE VISCOUS

**Manufacturer**—Astra Pharmaceuticals (Canada) Ltd., Toronto, Ont.

**Description**—Contains 2% Xylocaine hydrochloride in an aqueous solution adjusted to suitable consistency with carboxymethylcellulose. Cherry flavored for palatability.

**Indications**—Provides prompt and prolonged topical anesthesia of the proximal parts of the digestive tract. Controls hiccup and reflex vomiting, including severe vomiting of pregnancy, and relieves the discomfort of laryngoscopy, esophagoscopy and gastroscopy. Useful also in the symptomatic management of acute cardiospasm and pyloric spasm, stomatitis, pharyngitis and esophagitis.

**Administration**—Administered orally. Dosage as follows: Average dose: 1 tablespoonful administered orally.

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Gastroscopy and gastric intubation: 1 tablespoonful.

Esophagoscopy, esophagitis, stomatitis: 2 teaspoonfuls to 1 tablespoonful carefully distributed in the mouth and slowly swallowed, not followed by water.

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**Description**—Each yellow scored lemon-flavour tablet contains: Ascorbic acid 500 mg., menadione 10 mg.

**Indications**—For protection against hemorrhage in tonsillectomy and other surgery. Also in certain hemorrhagic states coexisting with ulcerative colitis, sprue and celiac disease. During last month of pregnancy.

**Administration**—Adults, one every 24 hours; children, one-half to one every 24 hours. To be used only as prescribed by physician.

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### NEURO-CENTRINE TABLET

**Manufacturer**—Bristol Laboratories of Canada, Limited, Montreal, P.Q.

**Description**—Each sugar coated tablet contains: Reserpine 0.05 mg.; phenobarbital 0.15 mg. (1/4 gr.); and centrine 0.25 mg. Reserpine promotes tranquillity and a sense of well-being. Phenobarbital induces sedation. Centrine inhibits gastrointestinal spasms.

**Indications**—Spastic conditions of the gastrointestinal tract, especially those associated with tension, anxiety and stress. Also as an adjunct in the management of spastic colitis, biliary colic, pylorospasm, peptic ulcers and morning sickness.

**Administration**—For oral use only. Dosage will depend on the individual patient's response as well as on the duration and severity of the condition. Adults: Usual dose is 1 or 2 tablets, 3 or 4 times daily. Children: Dosage according to age and weight.

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### SEDWELL

**Manufacturer**—Paul Maney Laboratories of Canada Ltd., Hamilton, Ont.

**Description**—Each teaspoonful contains: Fl. ext. belladonna 1/80 min., fl. ext. hyoscyamus 1/80 min., potassium bromide 5 gr., sodium bromide 5 gr., ammonium bromide 5 gr., zinc bromide 1/10 gr., ext. of hops 1/10 gr., fl. ext. cascara sagrada 1/10 min.

**Indications**—As an anticonvulsant in epilepsy and petit mal. Also as a sedative in insomnia, hyperthyroidism, alcoholic excitement, hot flashes and headaches of the menopause, etc.

**Administration**—Adults, as a single dose sedative, one to two teaspoonfuls. For continued use, one teaspoonful 3 times daily for 5 days, or 2 teaspoonfuls 3 times daily for shorter periods.

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### TRAWILL CAPSULE

**Manufacturer**—Charles R. Will & Co. Ltd., London, Ont.

**Description**—Each capsule contains: Dry extract rauwolfia 4% total alkaloids 10 mg. (equivalent to 0.4 mg. total alkaloids), butabarbital 16 mg.

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**Administration**—One capsule 3 or 4 times daily as prescribed.

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**Administration**—In acute schizophrenia — One 20 mg. tablet 3 times daily by mouth. Onset of action may occur within several hours. Usually 24 or more hours must elapse before clinical improvement takes place. Duration of blocking against hallucinations and delusions is relatively long lasting. When discontinued prodromal symptoms may recur in about one week.

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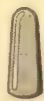
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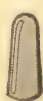
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# THE CANADIAN NURSE

## *L'Infirmière Canadienne*

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## Too Few for Too Many

IN ONE OF THE RARE MOMENTS left for reading in the busy life of a director of nurses, I opened a recently published book and glanced at the first chapter which was entitled "Too Few for Too Many." This punch line, as a radio script writer would surely call it, caused me to pause and reflect at length on the subject, for it dealt with the vexatious dilemma of too few workers to care for too many patients. This, I thought, was surely one of the first problems we must solve in order to fulfill adequately our motto for the next biennium which is "Nursing Service for the Nation." To what extent can we Canadian nurses fulfill our obligation of nursing service to the people of this country? Are we facing this problem from the angle of actual service given or are we speculating in figures, complacently thinking in terms of ratios that make us feel good, for we *do* have one nurse per 300 of population? Do we seriously consider that our pledge of rendering service means that it must be available to the rich and the poor; to the city dweller,

the mine worker and the farmer; in hospitals and at home; in industries and in schools? Are we fully aware that service means: performance of labor for the benefit of others or a means of supplying some general demand?

If we accept the fact that we have too few workers to care for too many patients what are we doing about it? We are asking for surveys and research studies but can we all truly say that



ALICE GIRARD

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Miss Girard, who is second vice-president of the CNA, is director of nursing at Hôpital St-Luc, Montreal.

when these are done we make great efforts to study, discuss and apply the recommendations? To what extent have we used the findings of the Head Nurse study? This could help us to a more effective utilization of the "Too Few".

Have we exploited to the fullest the possibilities at hand in the judicious utilization of our auxiliary personnel or are we too busy analyzing our fear of this group? If we cannot take upon ourselves the whole task of caring for the nation — and it seems evident that we cannot — then why not face the problem squarely and accept the fact that the auxiliary group is here to stay because we need it? Once reconciled to this idea the sooner we sincerely work on the integration of this group into the nursing family through adequate training, proper orientation and honest recognition of its merit, the more effective we will be.

Teamwork, when well organized, has helped us to redistribute the nurse's load of care and responsibilities and thus enhance her efficiency. Have we taken full advantage of this precious tool? There are a variety of ways by which we can improve the service we give with the resources on hand, but in order to do this each one of us must, in a way, be her own research worker. It is not given to everyone to be a creative thinker but everyone can scrutinize, analyze and evaluate her work with the object of changing or discarding the things that do not seem to fit in the complex pattern of our task as we see it now rather than continuing to think of it as it was twenty years ago.

Since we defined service as the per-

formance of labor for the benefit of others or as a means of supplying some general demand, it seems unwise to think that this can be done without the help of those who are to benefit from this service. The time has passed when it was improper to tell of our good deeds and to share our problems with the public. We have learned through business organizations that it pays to inform the consumer of the quality of a product and its proper utilization. Why shouldn't the public be aware of the problems the nursing profession faces in trying to staff more and more hospitals and public health nursing organizations since these are the result of public demand? It will eventually be the public who, as the consumer, will interpret to our various governments our legitimate demands as it makes known its needs and claims its rights. Yes, we do need to build good public relations if we want to attain our aims. Nursing service for all the nation is the public's right and it is the duty of our profession to be prepared with the help of the proper authorities to give this service or to admit failure. Failure is not in our tradition.

When we convene in Winnipeg next June let us all reexamine our aims and methods in the light of what we wish to accomplish. If our goal seems ambitious let us remember that a poet once wrote: "A man's reach must be beyond his goal or what is heaven for?"

ALICE GIRARD

*Chairman*

Committee on Nursing Service  
Canadian Nurses' Association

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Have you ever noticed?

When the other fellow acts that way, he is "ugly;" when you do it, it is just "firmness."

When the other fellow doesn't like your friends, he's "prejudiced;" when you don't like his you are simply showing that you are "a good judge of human nature."

When the other fellow spends a lot, he is a "spendthrift;" when you do, you are "discriminating."

When the other fellow takes time to do things, he is "dead slow;" when you do it, you are "deliberate."

When the other fellow holds on to his

money too tightly, he is "tight;" when you do, you are "prudent."

When the other fellow runs great risks in business, he's "foolhardy;" when you do, you are a "great financier."

When the other fellow says what he thinks, he's "spiteful;" when you do, you are "frank."

When the other fellow won't get caught in a new scheme, he's "backwoodsy;" when you won't you are "conservative."

When the other fellow goes in for music, pictures and literature, he's "effeminate;" when you do, you are "artistic."

— CONTINENT

# Mental Health for Nurses

W. H. CRUICKSHANK, M.D., D. PSYCH., D.P.H.

WITH EACH ADVANCING YEAR it is realized that more and more symptom complexes, formerly considered to be organic in nature, are explainable on the basis of reaction to emotional tension, fear, frustration and insecurity. These fears and frustrations, in some instances, lead to actual breakdown but much more commonly result in translation to physical symptoms that may be referable to almost any of the body systems and give rise to headaches, dizziness, stomach trouble, rapid heart and increased blood pressure, to extreme fatigue or even paralysis.

Emotional responses were designed originally to prepare the body for fight or flight in the face of danger. In a complicated society such as we now have, where one can no longer respond to emotion by physical fight or flight, these responses are expressed in different ways. They can be very disturbing and the basis of a great deal of ill-health. Thus emotional ills appear to be disorders of an increasing civilization.

The problem of emotional or mental ill-health within the population is no small one. The actual incidence of disorders of emotion and morale is not accurately known. It has been estimated, however, that such disorders account for as much as one-third of the total disability rate. About 60 per cent of the patients who attend outpatient departments of general hospitals do not suffer from organic disease.

In addition to its importance as a primary cause of lost time, the effect of emotion and attitude on duration of organic illness and on rehabilitation is not inconsiderable. If one adds to this the effect of non-disabling, unhealthy emotional reactions on efficiency, morale and cooperation the importance of the subject in relation

to overall nursing efficiency is almost overwhelming.

What is our definition of mental health? Mental health implies an ability to live in harmony with one's environment, to survive, to compete and to discharge one's responsibility in relation to personal capacities, to get along with people, to acquire skills that are consistent with ability, to obtain satisfactions, to accept and to live with or overcome personal limitations and to accept the consequences of one's behavior. Environment must be included in any definition of mental health. There are always the two variables, the individual and the environment. It may be important to point out that regardless of the qualities of the individual there are some environments in which a high level of mental health cannot be achieved.

One of my teachers would greatly simplify the definition of mental health by equating it to happiness and, in turn, to security. He would define mental ill-health as unhappiness and a feeling of insecurity. Under such a definition it can be readily seen that mental health is a relative state since no human is completely happy or completely secure or completely self-sufficient. This is not to be interpreted that few are mentally healthy. Some insecurity, and some unhappiness must be regarded as a normal rather than abnormal state.

What are the causes of mental or emotional ill-health? Those interested in the subject quickly come to realize that there is never, in a given case, one single causative factor, as was once thought. The cause never appears as a bolt from the blue, nor as a mysterious entity destined to implant itself at a particular period on unprepared soil. The cause is a process — something that moves and shapes itself in the passage of time. It doesn't just happen. The effects of heredity, child guidance and habit training, all the environmental influences and experiences in childhood and youth, of phys-

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Dr. Cruickshank is medical director, The Bell Telephone Company of Canada, Montreal.



ical health, culture, etc., all have a bearing on ultimate emotional stability. Surely this concept of etiology provides increasing incentive in our urgent desire to promote mental health and to prevent mental ill-health. That we have a long way to go in mental hygiene is suggested by the large number of people who achieve chronological maturity while still retaining emotional immaturity to a degree that interferes with their ability to live in harmony in the situation in which they find themselves.

On the bright side, however, we have accumulating evidence to suggest that *behavior can be predicted and that the process of personality maturation can be influenced*. There is now good reason to believe that a child who is loved will almost invariably be capable of loving others. There is now ample evidence to show that a child who has not had love will be hostile and will lack trust in people; that a child who has been over-protected, never allowed the opportunity to develop independence appropriate to his age, will be neurotic and dependent; that a child who grows up in association with people who have respect for the rights of others and the laws of society, will also have respect and consideration for the rights of his fellow-men; that a child who has been rejected will usually be resentful, often delinquent and always insecure. Much progress has been made in the area of child guidance. Our mental hygiene activities, however, must not stop with parent education and teacher training but must be extended throughout adult life. The maturation of personality does not stop with the cessation of physical growth. Under favorable conditions it may extend throughout the major period of adult life.

Do these fundamental mental health observations just mentioned have any bearing on the mental health of nurses? Are nurses susceptible to the effects of love, recognition, rejection, over- and under-protection, satisfaction, rewards and discipline? We know that adults on the surface are more sophisticated. We know that they have been conditioned by all previous life experience. In spite of this,

my observations would lead me to believe that the fundamental responses to love, protection, rejection, recognition and other forms of stimuli remain relatively unchanged in the nursing profession. That nurses like to be recognized, like to have at least a measure of control over their own affairs, like to have the opportunity to develop skills appropriate to their individual capacity and, through the acquisition of skills, to enjoy a measure of independent security, unfortunately, is a relatively recent discovery.

Observation would tend to suggest that the mental health needs of students in a school of nursing are not fundamentally different from what they are in the home. Just as parents now recognize the importance of participation, responsibility, example and discipline in child development, so schools of nursing should look at the advantages of providing those conditions of work that foster the development of nurses who are mature and are capable of independent thought and action.

Nurses like to be recognized. Nurses like a democratic opportunity to advance and to acquire independent security consistent with their efforts. That work should be a method rather than just a means of living is a new concept but fundamental to mental health.

The mental health needs of nurses are intimately related to the work situation. The acute emotional reaction which gives us windy indigestion, clammy hands, rapid heart and difficult breathing, for example, when one has to give a speech, does little or no harm to health. Chronic emotional response to a grievance, to frustration, to continued fear or to lack of job satisfaction, undermines health, produces inefficiency and brings about a desire for a change in the order of things. Chronic anxiety undermines health. The importance to the career worker of a satisfactory job situation is such that if she achieves satisfaction in her job her private conflicts become of secondary importance. There is a good deal of evidence to suggest that the opportunity to acquire skills through vocation and avocation is probably the most important single factor in mental health in our com-

petitive society. The more skills we have the more independently secure we are. It is more difficult to take away our skills than to take away any of our other possessions. Our skills are our greatest source of recognition and our main hope of immortality. People can stand great adversity and still be happy if acquiring skills and progressing toward a goal.

Work and the work situation, therefore, are important to mental health. As would be expected, they are also important as causes of mental ill-health. Of all the mental health problems it is probably true that tensional states are by far the most common. Many tensional states arise in the work and work situation of the average nurse.

TENSION

"Tension" is spoken of rather glibly and yet it is rather difficult to define. Dr. D. E. Cameron defines tension as a state of "preparedness for action." This is a very practical definition. The physiologists have for years used the word "tone" to describe the state of a muscle which enables it to act efficiently and immediately in response to the will. Preparedness for action is a desirable state and, as would be ex-

pected, is related to efficiency. A muscle that is without tone is clumsy and ineffective when called upon to undertake precise movement. Likewise the person who is not prepared for action is ineffective. We all recognize the nurse who has a healthy level of tension, who is prepared for action. She is referred to as a self-starter. The head nurse likes to have her on her ward.

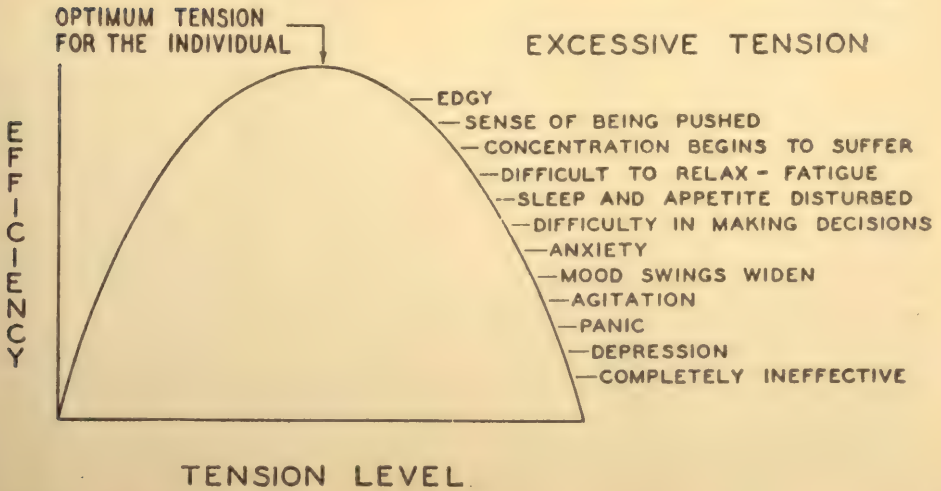
Some people have a low tension level and require continual prodding. They are usually inefficient.

The accompanying figure shows graphically the relationship between the efficiency and tension level. As tension is raised efficiency increases. As tension is increased beyond the optimum efficiency goes down.

The responsibility of the supervisory staff in our hospitals is to maintain the tension of nurses at an efficient level. Sometimes they fail to realize, however, that when the tension level is raised too high, efficiency goes down. Excessive tension, when prolonged, not only reduces efficiency but undermines health.

The effective nurse is the one who can maintain her tension level at or near peak efficiency. She will occasionally get the wheels going too fast and then cut back a bit as she notices that

EFFECT OF TENSION ON EMPLOYEE EFFICIENCY





she becomes edgy or irritable and not quite so effective. To some, however, such symptoms are merely a signal calling for greater effort or increased activity. When this occurs, a vicious circle is established with productivity going down and tension going up. Under these conditions typical symptoms develop. Concentration begins to suffer. Relaxation is impossible. Fatigue develops. Adrenalin is pumped into the blood stream too fast. This is the fear reaction. Sleep and appetite are disturbed. The heart may start to pound. Decisions become increasingly difficult. With indecisiveness comes real anxiety followed by depression, a feeling of hopelessness. Agitation usually precedes panic. At this stage, such a person needs positive help. Relatively few people go through the entire cycle, but, many nurses do get over into dangerous tension levels with adverse effects both on their work and their health.

The ability to withstand tension varies markedly from person to person. It is important to realize that everyone is susceptible to unhealthy tension levels under certain conditions. Everyone has a breaking point. In some, however, the tension tolerance, for one reason or another, is very low. The mere effort of living, even in a protected environment, may produce disabling tension levels. At the other end of the scale some can apparently withstand almost endless tension-producing stimuli with surprisingly little in the way of impairment to efficiency.

What causes the wide variation in the susceptibility of people to tension? There may be heredity factors. These do not seem to be very important. Most of us would agree that environmental influences are more important in determining our personality development and our ability to withstand tension. The ability to withstand tension depends on all of our past experience including our habit training, our opportunities to accept and deal with responsibility, our intellectual capacity, our physical health and, undoubtedly, on our philosophy of life.

#### SUSCEPTIBILITY TO TENSION

There are certain groups of people

who are characteristically more susceptible to tension than others:

1. *Physically handicapped* persons do not stand tension well. Nurses with hearing defects, fallen arches, arthritic involvements, etc., compete unfavorably, both socially and economically, and unless they possess unusual personality maturity tend to be tension prone.

2. *Advancing years* may be a factor. Our society tends to discard age and experience in favor of youth. Older nurses are at a disadvantage and they tend, for this reason, to be tension prone. There are many reasons for this. Often older people have not achieved the goals they have set for themselves. They have become less adaptable. Often they have devoted a major portion of their lives to one position and they may resent new authority. The pre-retirement group are particularly susceptible to tension and require careful and extremely considerate leadership.

3. People with certain *personality characteristics* are tension prone. Those who lack confidence, those who are hostile and do not trust people, those who find it difficult to work with people, those who are easily frustrated or are highly sensitive are prone to excessive tension.

4. The *type of motivation* in the individual has a bearing on susceptibility to tension. Those who are over-motivated are impatient and tension prone. Those who are poorly motivated are tension prone if prodded. Those with conflicting motives tend to be tension prone. Those who are over-motivated who also have limited capacity, are particularly susceptible to tension.

#### TENSION STIMULI

So people vary in their ability to withstand tension. The process of living inevitably produces contact with tension-producing stimuli. These may be related to problems in the home, in the community or at work. Some of the factors that are tension-producing may be listed:

1. *Responsibility factor* — The amount and kind of responsibility have a bearing. Strangely enough, work with not enough responsibility will produce excessive levels of tension in aggressive people just as readily as work with



excessive responsibility. Any form of supervisory work, from the director of nursing down to the most junior assistant head nurse, carries a potentially high tension rating. It is important to realize that when responsibility is clearly defined it is much less tension-producing than indefinite or ill-defined responsibility. Responsibility accompanied by authority is less tension-producing than responsibility that is devoid of authority. These are important considerations in the placement of staff.

2. *Physical factors* — Where the physical demands of the work are beyond the physical capacity of the nurse, tension is prone to develop. This is readily observed in the older nurses who return to work, perhaps after years of separation from actual nursing care.

3. *Unpredictable flow of work* — Surges of responsibility and patient-load affect the level of tension. The adverse effect is exaggerated if there does not seem to be justifiable cause for the change of pace.

4. *Intellectual requirement* — Work requiring either more or less capacity than the individual nurse has tends to produce insecurity or boredom, with resultant unhealthy tension levels.

5. *Pressure* — The feeling of being pushed either by the volume of work to be done or by time in which to do it effectively is typically tension-producing.

6. *Repetitive tasks* — Doing the same routine duties over and over again usually demands only a limited range of the nurse's skills and thus may be tension-producing. This is a major problem in considering the mental health of nurses.

7. *Creative work* — There are fewer opportunities for creative or imaginative effort in nursing activities than in many other professions or occupations. In some persons, this lack of opportunity for recognition may produce tension.

## WORKING ENVIRONMENT

The working environment has a bearing on the tension level. Some of the factors that are of importance in this connection may be listed:

1. *Supervision*: The administrator's job is to keep the tension at an efficient level. If it is too low, work suffers.

If it is too high both work and health suffer. The leadership ability of the supervisor is important in this regard. When staff nurses lack confidence in the supervisor or the head nurse the tension level of the entire group is affected. If the supervisor is a poor leader, if she discriminates, if she fails to recognize good work, the tension level is affected and poorer work results. *Good supervision will go a long way toward maintaining healthy levels of tension in any situation.*

2. *Rigid standards* tend to raise tension levels. This is particularly so if the need for such rigidity is neither understood nor considered necessary by the staff members.

3. *Non-Acceptance*: In group activities it is essential to be and feel a part of the group. A nurse who feels that she is not accepted by the head nurse, by the staff on the ward or even by the patients will be inefficient and tension prone. A supervisor who is not accepted by subordinates will develop unhealthy tension.

We have reviewed at some length factors that influence tension level, including variations in susceptibility to tension. We have discussed the adverse effect of tension on physical and mental health and on the level of work. What can be done about it? How can we develop working conditions that will avoid these undesirable results?

It is important again to state that an optimum level of tension is essential. In fact the whole administrative staff has an obligation to keep the tension of the nursing team at an effective level. This is not only healthy for the work to be done but there is some indication that it is also healthy for the nurses involved. However, the prevention of unhealthy or inefficient levels of tension is one of the big challenges in a mental hygiene program.

## MENTAL HEALTH PRACTICES

This brings us to a discussion of desirable mental health activities:

1. *Hospital Policies*: The mental health program in any hospital starts with its broad policies of administration. Those policies that enhance the qualities of the individual nurses, both graduate and student, by contributing to their

satisfactions and their recognition, those that encourage their participation and foster their growth and development contribute to their mental health. Those policies that degrade the status of the individual produce anxiety, feelings of tension, insecurity, and inevitably result in mental ill-health.

2. *Leadership*: Just as the major share of responsibility in child guidance has fallen on the shoulders of parents and teachers, so the burden of mental health and morale in hospital work must fall on those who are in authority — the doctors, the administrative officers, the instructors, the supervisors and head nurses. All group effort depends on organization which demands leadership.

Leadership may be defined as the skill in developing cooperative effort. Good leadership is probably the most important single factor in any mental health program. It is a skill requiring great ability and wide experience. Leaders are not born. They acquire their skills by training and doing. The selection, continued training and development of leaders is an important challenge. The crucial inter-personal relationship on the ward takes place between the nurse and the first level of management. Unfortunately the first level of management, the head nurse, is usually the least experienced. She may or may not have special aptitudes of leadership. She often has not had extensive experience and certainly is not likely to have had much practice in leading people.

3. *Conditions of work*: Working conditions which provide, among other things, freedom from discrimination, a democratic opportunity to advance, work assignments that are meaningful and lead to the development of useful skills, a healthy degree of security, and rewards that are roughly commensurate with effort, are fundamental to morale and to mental health.

4. *Placement (vocational guidance)*: Careful placement of nurses in positions from which they can gain satisfaction is a vital consideration in mental health. This is particularly true in the appointment of young graduates. When they are placed in positions that are beyond their ability, they become insecure and unhappy through lack of accomplishment. On the other hand, a nurse

obtains little in the way of lasting satisfaction from work that requires only a limited portion of her ability. The challenge in placement, then, is to ascertain the interests, abilities and aptitudes of applicants and to place them at work for which they are physically and mentally suited.

5. *In-service training*: An adequate orientation program, including introduction into the hospital and into new assignments, does a good deal to overcome the insecurity and tension which always results when people find themselves in new situations. In-service training is extremely important in facilitating the acquisition of new nursing skills. Management training, including such subjects as human relations, observation and study of human behavior, conference leadership, communication, administration etc., offers tremendous opportunities for improving the leadership skills, of our potential supervisors.

6. *Medical services*:

(a) *Diagnosis and placement*: The early recognition and suitable placement of the tension prone is important in the maintenance of health and good work. Ready access to health counselling services, the preplacement examination and the periodic examination provide important opportunities for preventive work on an individual basis.

(b) *Treatment*: Prevention and case-finding are important parts of the health job. Emotional first aid measures can often prevent breakdowns requiring prolonged therapy. In the average hospital health service, physicians and nurses undertake much more counselling in relation to mental health problems than in relation to organic disease. Their work would be relatively ineffective unless they were students of human behavior.

(c) *Education*: You cannot teach mental health. Assistance in personality development, through counselling, is constructive. Those who like people can readily become students of human behavior and with sufficient experience can learn to interpret the significance of behavior patterns.

(d) *Rehabilitation*: The early and safe return to work following illness, organic or otherwise, is an important consideration in the maintenance of health. Disabling injury or disease al-

ways produces insecurity. The mental health factors are usually the major consideration in rehabilitation programs. They are much more difficult to deal with than organic factors. Rehabilitation following major mental illness is a problem requiring a highly coordinated effort.

That health, morale and efficiency are inseparable is a well-established

fact. That the maintenance of emotional health offers the greatest challenge to medicine, psychiatry and to public health, unfortunately has been recognized only within recent times. That a nurse's job, her relationships to her colleagues and to her supervisors are crucial factors in determining her mental health and morale requires much more attention.

## L'Evolution de la Cardiologie et ses Problèmes

PAUL DAVID, M.D.

### ADOLESCENCE ET AGE ADULTE

**I**L EST UNE MALADIE de coeur qui par son importance et ses ravages prédomine nettement dans cette période de vie qui va de 5 ans à 40 ans et c'est la maladie cardiaque rhumatismale. Le rhumatisme articulaire encore appelé inflammatoire ou maladie rhumatismale est responsable d'au moins 90% des lésions acquises: sténose mitrale, insuffisance mitrale, sténose aortique, insuffisance aortique, maladie mitrale, maladie aortique, tricuspidite etc. . . . Il est quelques notions qu'il faut retenir, sur lesquelles j'insiste chaque fois que l'occasion m'en est donnée depuis 8 ans, notions qui avec le temps devraient être comprises dans notre milieu si jamais on organise une lutte efficace contre cette maladie.

1. La maladie rhumatismale frappe avec prédilection l'enfance (4 à 18 ans).

2. L'agent causal ou étiologique de la maladie n'est pas connu.

3. On semble avoir établi un rapport étroit entre elle et le streptocoque hémolytique. Pour cette raison, elle succède presque toujours à des infections respiratoires de la gorge et particulièrement des amygdales.

4. La maladie rhumatismale cause des lésions endocarditiques particulièrement

des valvules chez au moins 50% des sujets malades.

5. Le rhumatisme articulaire aigu est souvent peu tapageur et donne des symptômes qui passent malheureusement inaperçus pour les parents des victimes et il faut le dire pour bon nombre de médecins qui les traitent.

6. Un traitement précoce et bien conduit en milieu bien surveillé semble diminuer nettement l'incidence des lésions cardiaques consécutives.

7. Nous constatons avec regret qu'aucun effort sérieux n'est fait dans la Province de Québec en vue de nous aider à éduquer la population et nous permettre de mieux soigner cette maladie.

8. Le traitement de la fièvre rhumatismale s'échelonne sur plusieurs mois et repose avant tout sur le repos.

9. Il faudrait un petit hôpital spécialisé où ce traitement pourrait être continué aussi longtemps que persistent les symptômes d'activité avec programme de repos, de distraction et d'étude pour les enfants.

10. Il faudrait que la cortisone puisse être donnée à chacun dès les premiers symptômes sans égard pour son coût élevé.

11. Il n'existe pour le moment aucun moyen certain de diagnostic, aucune drogue absolument spécifique.

12. Il semble que la pénicilline donnée prophylactiquement et sur de longues périodes diminue l'incidence de

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la maladie et empêche les rechutes.

Sachant que l'incidence du rhumatisme articulaire aigu, que les lésions cardiaques et de leurs conséquences sociales sont infiniment plus meurtrières que celles de la polyomyélite, je ne puis m'empêcher de supplier nos services de santé de nous prêter leur concours. Peut-être alors pourrions-nous, quelque part, découvrir une thérapeutique du type "Salk" pour accroître les défenses naturelles de l'organisme contre cette maladie.

Que faire vis-à-vis d'une lésion cardiaque constituée et ceci en général dans les années qui suivent une ou plusieurs poussées rhumatismales? Sur la lésion elle-même aucune drogue n'agit. Les thérapeutiques médicales éloignent les complications, les adoucissent, les préviennent parfois, rien de plus ou de mieux. Elles ne peuvent modifier l'architecture valvulaire d'une sténose ou d'une insuffisance. Force est donc de recourir à la chirurgie des lésions acquises qu'a mise au monde Bailey et son groupe en 1948. Cette chirurgie a fait ses preuves dans les lésions sténosantes, en particulier la sténose mitrale. Cette chirurgie se pratique aujourd'hui dans tous les services importants de cardiologie du monde entier. Notre expérience porte sur 185 patients opérés pour sténose mitrale; 6 patients pour sténose aortique; 1 patient pour insuffisance mitrale et un patient pour sténose tricuspide.

Notre premier malade fut opéré par le Docteur Edouard Gagnon à l'Hôpital Notre-Dame en février 1950. Avec cinq années de recul, nous nous sommes persuadés des énormes bienfaits de la chirurgie cardiaque, en particulier de la sténose mitrale où notre expérience est la plus grande. Mais ici encore nous croyons très important de poser des diagnostics très précis et d'éviter à tout prix des opérations inutiles. Sur les 185 malades que nous et nos collaborateurs avons présenté aux chirurgiens, nous comptons deux erreurs, pourcentage extrêmement faible de 1.1% lorsqu'on connaît les difficultés que constitue par exemple l'interprétation d'un souffle systolique de pointe. Il faut réaliser que malgré une intervention réussie la maladie de base persiste et que pour

cette raison nous ne prétendons pas guérir ces malades. Notre expérience et celle de nombreux centres a abondamment prouvé que ces opérations prolongent la vie des malades, les soulage de leurs symptômes et les mettent à l'abri des complications habituelles de la maladie pour une période de temps que seul l'avenir précisera.

#### AGE MÛR ET VIEILLESSE

Je laisse à chacun de déterminer à quelle décade de vie commence la vieillesse. Admettons, toujours pour les fins pratiques de ce travail, que l'âge mûr a ses débuts à la quarantième année. On peut encore exceptionnellement trouver des lésions congénitales, assez souvent des lésions rhumatismales mais la pathologie cardiaque est franchement dominée par les maladies dégénératives: maladie hypertensive d'une part, coronarienne c'est-à-dire angine de poitrine et thrombose coronarienne d'autre part. Cela ne signifie pas que ces deux pathologies ne puissent être rencontrées avant. J'insiste même sur l'impression que nous avons de diagnostiquer des angines et des thromboses chez des individus plus jeunes que l'âge habituellement cité dans les livres et les articles anciens. Il n'en demeure pas moins qu'après quarante ans la majorité de nos cardiaques rentrent dans le cadre de ces deux pathologies.

#### HYPERTENSION ARTÉRIELLE

Sauf exception, c'est une maladie au long cours qui s'échelonne sur une vingtaine d'années environ avant de donner ses complications cardiaques, vasculaires ou rénales habituelles. La gravité de l'hypertension se juge par le chiffre de la pression diastolique et par ses répercussions sur le cœur et les reins. L'examen du fond de l'oeil permet une évaluation de l'atteinte artérielle réelle.

La cause de cette maladie, en admettant qu'elle fut unique, est inconnue. Il serait trop long et en dehors du cadre de ce texte d'énumérer même brièvement les nombreuses théories édifiées sur ses très nombreuses composantes.

Depuis quelques années, cinq au maximum, le traitement médical donne des résultats qui dépassent les espoirs des médecins les plus sceptiques. De mois en mois s'allonge la liste des hypotenseurs efficaces. Cependant le traitement médical exige des connaissances approfondies car il n'est pas sans danger. Des doses trop petites ne donnent aucun résultat et des doses fortes sont facilement toxiques. De plus, ces médicaments sont très coûteux et les visites médicales doivent être rapprochées. Obstacle sérieux pour ceux dont les moyens financiers sont limités. Ici encore devant la masse des hypertendus, maladie extrêmement répandue, on s'étonne de l'apathie d'action de nos groupements en quête de nouveaux territoires de philanthropie. Evidemment, l'hypertension n'est pas contagieuse mais on sait qu'un facteur héréditaire joue un rôle non négligeable si bien que les hypertendus de demain le seront en large partie à cause des hypertendus d'aujourd'hui. Un traitement chirurgical a sa place dans le traitement de certains cas d'hypertension.

#### MALADIE CARDIAQUE CORONARIENNE

Le drame coronarien peut se jouer en quelques secondes. Il peut durer plusieurs années. Maladie courante qui frappe partout autour de nous, tue subitement les uns, en réduit d'autres à une invalidité physique absolue, ralentit, démolit toute une masse d'homme et cela particulièrement entre 40 et 65 ans. Maladie dégénérative, pas nécessairement de vieillissement, dont l'artériosclérose sélective sur l'arbre coronarien, diminue le débit du sang qui nourrit le muscle cardiaque. Maladie traîtresse que rien ne peut prévenir et que peu de chose peut efficacement arrêter. Ennemi no 1 du male mûr car jusqu'à l'âge de 60 ans trois hommes pour une femme en sont atteints. Nos bureaux regorgent de coronariens et c'est pitié de réaliser comme nous pouvons peu pour eux. Cela ne veut pas dire que nous ne pouvons rien. Ici plus qu'ailleurs doit être appliqué le principe célèbre et vrai du "primo non nocere". L'étude de la crase sanguine, des phénomènes de coagulation et la thérapeutique anticoa-

gulante sont des apports récents de grande valeur et qui solutionnent en petite partie cet immense problème. J'aimerais ici encore voir nos services de santé s'intéresser, comme nous, à ce problème dont l'intérêt pratique est évident. J'ai un parent, et ce cas est loin d'être unique, qui est mort subitement de thrombose coronarienne à 35 ans en se rendant à son travail. Père de famille comme bien d'autres, il a laissé sa femme et trois garçons. Avez-vous déjà songé à ce que la société faisait pour aider, si besoin est, dans de pareilles circonstances? La pension est-elle le seul apanage des femmes et des enfants de soldats morts au champ d'honneur? Chaque homme de ce pays ne concourt-il pas, en temps de paix, à son épanouissement et sa prospérité? On s'occupe des très pauvres et c'est bien mais il faut songer à l'immensité des fortunes moyennes qui se refusent en peinant comme des dératés à déchoir physiquement, moralement et matériellement. La chirurgie tente depuis vingt ans de trouver une solution optimiste à ce problème. Elle est prometteuse mais encore expérimentale. Je mentionne, parce que canadiens, les travaux remarquables de Mercier-Fauteux et ceux que poursuit actuellement Arthur Vineberg dans ce domaine.

#### IMPORTANCE SOCIALES DES MALADIES DU COEUR

1. Les maladies de coeur tuent à elles seules pratiquement autant d'individus que toutes les autres maladies réunies. Quelques chiffres pour confirmer cette assertion: Etats-Unis 52.3%; Canada 43.5%; Montréal 37.2%.

Devant ces chiffres pourtant éloquentes, il est curieux de constater l'esprit de fatalisme qui empreint les responsables de nos services de santé, comme s'il était normal de mourir de son coeur, comme si rien ne pouvait être fait.

2. Les maladies de coeur, nous l'avons vu, ne sont pas l'apanage des vieillards, ni d'un sexe plutôt que l'autre. A preuve les statistiques que nous avons compilées sur les malades hospitalisés à l'Institut en 1954.

a) Nombre total de malades hospitalisés	725
Nombre de femmes	



hospitalisés ..... 351

Nombre d'hommes

hospitalisés ..... 374

- b) Tableau des âges respectifs dans les deux groupes :

Nous constatons que les malades hospitalisés pour leur coeur l'ont été avec la plus grande fréquence — entre 30 et 50 pour la femme — entre 50 et 60 pour l'homme. Réfléchissons un instant sur l'importance économique de ces hommes et femmes, rendus plus ou moins invalides à des âges particulièrement utiles à la société. Ces chiffres démontrent, à mon point de vue, que les cardiopathies sont très loin d'être l'apanage du vieillard.

3. Les maladies du coeur imposent, quelle que soit leur étiologie, une réduction de l'activité physique par l'apparition de deux symptômes dominant : la dyspnée d'effort et la douleur thoracique d'effort.

Imagine-t-on l'importance de ce fait quand la plus grande partie d'une population vit essentiellement sur sa capacité d'effort physique? Pensons à la grossesse, aux soins des enfants, à l'entretien du foyer! Pensons aux conséquences sociales de l'ouvrier immobilisé, du travailleur manuel qui n'a pas eu la préparation ou n'a pas les aptitudes pour devenir du jour au lendemain un collet blanc!

4. Les maladies du coeur sont essentiellement chroniques et elles s'étagent sur des années d'évolution. Par leur chronicité, elles supposent des soins médicaux constants, la prise quotidienne de médicaments, le besoin d'hospitalisations répétées, des arrêts de travail souvent prolongés, des dépenses médicales constantes. Situations qui crée le cortège de tous les drames matériels, psychologiques et sociaux de n'importe quelle maladie chronique.

5. Le cardiaque bien compensé est un "handicapé".

Même lorsqu'il ne ressent aucun symptôme, le cardiaque, avant même de souffrir physiquement subit les ennuis de sa maladie.

L'assurance dont les opérations financières n'ont aucune visée philanthropique refuse systématiquement tout individu hypertendu, coronarien ou porteur d'une lésion congénitale ou acquise. Bon nombre d'assurances-maladies exigent au départ une excel-

lente santé. De plus en plus la grande industrie par le truchement des unions ont créé des fonds de retraite, de pension de maladie etc. Mais, et j'insiste, à l'embauchage le candidat est examiné et seul l'individu sain est admis.

Cependant le cardiaque peut travailler lorsqu'on n'exige pas de lui un effort physique trop considérable. Ne pourrait-on pas lui confier ces multitudes de positions sédentaires qui sont souvent occupées par des hommes vigoureux et sains. Un immense effort est fait dans ce sens par nos amis américains. Les lois les plus élémentaires de la charité chrétienne pourraient jouer dans la plus catholique des Provinces du Canada! Qui mettra sur pied une société ou une association d'aide et d'entre-aide aux cardiaques? Qui s'intéressera au sort de nos malades?

Parce que nous sommes convaincus que notre seul devoir n'est pas de traiter la maladie seulement, nous avons mis sur pied un modeste service social à l'Institut. Mademoiselle Henriette Tenaille, en charge de ce service, essaie d'améliorer les situations les plus désespérées. Notre effort est une goutte d'eau mais il est un témoin de notre préoccupation et de nos pensées.

## LA MÉDECINE MODERNE CÔÛTE CHER

Ne pas l'avouer c'est vouloir intentionnellement cacher une vérité. L'avouer c'est donner raison aux milliers de personnes dont tout acte médical ou hospitalier est jugé sur son prix. Dans les salons, on discute les prix du médecin, du chirurgien, de l'hôpital, d'un test de laboratoire, d'un examen radiologique avec la même passion que les cours à la bourse, les nouvelles créations de la haute couture, le chauffage, le loyer ou les taxes. "J'ai enrichi le docteur Untel de 500 dollars pour me faire faire la grande opération et l'Hôpital de 2,000 dollars. C'est révoltant, le café était froid, j'ai attendu 18 minutes une nuit pour la bassine, j'ai payé pour des tas d'exams inutiles, on m'a fait voir par tout un groupe de spécialistes pour rien." Elle est pourtant bien cette femme aujourd'hui, elle ne souffre plus



et elle ignore peut-être que ces 2,500 dollars l'ont guérie d'un cancer au début. Pour ce prix, elle vivra dix ans de plus, 250 dollars par année, moins que le prix de deux paquets de cigarettes par jour! Le médecin n'est pas un être humain. Il a perdu aux yeux du monde le droit d'avoir une vie de famille, de se reposer, de prendre des vacances et surtout de charger des honoraires. Les hôpitaux sont des asiles de charité qui emploient un personnel formidable et qui devraient boucler leur budget avec les prières des honnêtes gens.

Malgré les exagérations, les jalousies mesquines, les interprétations malveillantes, les connaissances inadéquates des saboteurs du médecin et de l'Hôpital un fait surnage, indéniable: la médecine, surtout hospitalière, coûte cher.

Nous savons qu'un séjour hospitalier pour opération cardiaque coûte au malade qui peut payer un minimum de 2,500 dollars. Mais nous savons également que la même opération ne coûte absolument rien au patient d'assistance publique qui en plus de ne pas payer le chirurgien, le médecin, l'anesthésie, le radiologiste, l'homme de laboratoire, les gardes-malades des soins post-opératoires contribuera pour un déficit d'au moins 1,000 dollars dans le budget de l'institution. Le calcul est simple. Admettant que ce malade est hospitalisé 30 jours, nous recevons très exactement  $30 \times \$7.50$  de l'assistance publique — \$225.00.

Evidemment, il y a dix ans, on n'opérait pas sur le coeur et pour cette raison, moins de dépense. Il fut un temps où les rayons X n'existaient pas, où l'électrocardiographie n'avait pas été inventée. Il fut un temps où il n'y avait ni médecin, ni hôpitaux. Il fut un temps où la médecine ne coûtait rien et où on mourrait en moyenne à 30 ans! Ce ne sont pas les hôpitaux, ce ne sont pas les médecins qui coûtent cher, c'est la médecine avec ses progrès, ses raffinements, ses exigences, son désir de poser des diagnostics certains aboutissant à des thérapeutiques sûres. Et la médecine c'est l'étude de l'être humain si complexe qu'il n'a et ne pourra jamais être reproduit sans des cellules mâles et femelles. L'être humain si complexe

que malgré des siècles de recherche il demeure "l'homme cet inconnu" de Carrel. Et pour le guérir des innombrables maladies dont il peut être atteint, on critique ces minutieux examens que le médecin, à savoir limité, doit utiliser dans le seul but d'aider un autre être vivant comme lui. La médecine coûte cher. Et l'automobile, le confort de la vie moderne, un avion à réaction, une pile atomique, une seule expérience de destruction dans les déserts du Nevada! Mais j'admets qu'avec les taxes, avec la vie, avec les loyers, le chauffage, les enfants et tout le reste, la médecine coûte cher au gagne petit et à l'individu de classe moyenne, d'autant plus que la maladie est une malédiction jamais méritée et rarement prévue.

Nous nous orientons inexorablement vers une médecine sociale, souhaitable d'ailleurs pour les petits et pour les institutions. Des expériences ont été faites ailleurs, en Angleterre, dans les pays scandinaves, en France pour ne citer que celles que je connais. Il faut admettre qu'en France, en particulier, les sécurités sociales ont grandement aidé le malade sans nuire au médecin. Nous n'avons personnellement aucune objection à une médecine socialisée en autant que soit respectée la liberté du médecin, du malade et de l'institution hospitalière. Nous croyons même que le peuple dont le principal souci est l'insécurité y trouvera réconfort, joie et paix. J'admets volontiers le principe de l'être bien portant payant en taxes pour son frère malade. Je suis de ceux qui croient que la santé est la richesse la plus enviable de chaque être humain. Mais, ne nous faisons aucune illusion, la médecine sociale continuera à coûter cher, peut-être davantage même parce qu'elle nécessitera une armée de fonctionnaires. Elle coûtera moins à chacun et davantage à tout le monde. L'homme continuera à se plaindre mais moins des médecins et des hôpitaux et davantage des taxes. Mais pendant ce temps, le malade lui, sera traité sans avoir un oeil sur la médecine et l'autre sur la portefeuille.

#### RÔLE DE L'INSTITUT

En m'écoutant vous avez déjà com-

pris nos buts et saisi quelques-unes de nos réalisations. Nous essayons de faire mieux sans prétendre faire plus qu'ailleurs. Nous n'espérons pas tout découvrir et rayer les maladies du coeur du tableau des maux dont l'homme aura toujours à souffrir.

Nous essayons avec le plus de compétence, le plus de lucidité, d'honnêteté et de dévouement possibles d'aider la cause des maladies du coeur. Notre programme comprend :

Le diagnostic et le traitement des maladies du coeur.

L'enseignement de notre spécialité aux médecins praticiens.

Le désir de prouver l'importance morale et matérielle des maladies du coeur.

Le développement de moyens d'aide et de réhabilitation aux cardiaques.

Le souci de donner à notre population du Québec le profit immédiat des découvertes qui concernent la cardiologie.

Le besoin de posséder toute l'instrumentation nécessaire à la meilleure pratique possible de la cardiologie.

L'obligation de faire de la recherche pratique et basale.

L'essai d'intéresser les services de santé de la Ville, de la Province et du Canada à collaborer avec nous et à nous aider matériellement. Je dois malheureusement souligner un échec complet vis-à-vis des autorités Municipales et Provinciales. Nous pensons un jour réussir en prouvant davantage nos besoins et en expliquant mieux nos buts véritablement, sincèrement et uniquement humanitaires.

Puis-je, mesdemoiselles infirmières, compter sur votre appui moral dans l'édification d'une oeuvre imparfaite mais dont le seul but est d'aider, de soulager les misères de notre frère, le malade du coeur. Compris ainsi, vous réalisez que nous osons dépasser et de beaucoup le seul cadre d'une cardiologie scientifique où seule a de l'importance la maladie. Nous croyons au contraire que le malade et chaque malade seul est important.

J'aurai moins de remords d'avoir abusé de votre très bienveillante attention si ce trop long travail peut avoir contribué à vous mieux faire comprendre quelques-uns des problèmes de la cardiologie moderne.

## In the Good Old Days

(*The Canadian Nurse* — FEBRUARY, 1916)

Breast feeding for the first six months is desirable because: (a) The mother's milk furnishes some little known substances which act in a protective way against infections of various kinds; (b) because after a child is six months old artificial feeding is much easier. It has been found that rickets is fairly common among infants that are taken off the breast feedings too soon. Scurvy is also seen though less frequently.

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Quinton, in 1910, advocated the use of sea water plasma to offset dehydration in acutely ill patients. McKenzie, in 1912, went further and used normal saline solution made with sterile distilled water. In thus raising the quantity of fluid in the tissues there is an increased secretion of urine and a resultant increase in the elimination of toxins.

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The training school for nurses represents one of the most important departments of a hospital both because of its function in nursing the patients and because of the public de-

mand for trained nurses. It is an interesting fact that those who organized some of the early schools had a much better conception of the need of nurse training schools as educational institutions than those who are responsible for the majority of the schools today.

Practically every hospital has its training school. In most instances the hospital has established the school, not with any deep-rooted desire to train nurses for the purpose of serving the public generally or because of any particular interest in education along this or any other line, but with one idea paramount — to get the nursing work of the hospital done in the simplest and cheapest possible manner.

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In connection with every large hospital there should be a convalescent home, under public or private auspices, where patients may receive necessary care while convalescing thus relieving the hospital and minimizing expense.



# Counterpane Land

LOUISE PRICE BELL

ILLNESSES OF ALL KINDS are as inevitable as taxes when there are youngsters in the family. Parents of today are usually pretty intelligent about the care of their children, make sure that they have proper foods to give them well-balanced diets, that they get a maximum of rest and fresh air. But even with advanced medical knowledge, "sniffles" will occur, the "children's diseases" descend upon the family, and in most families some Tarzan-minded lad is sure to fracture an arm or leg! All these things mean that the child, or children, will be forced to spend some time in bed. For an active smallster this can be a boring, tedious, unhappy period. Or it can make the "Land of Counterpane" a delightful place. The difference rests with the parents, most of all with the mothers.

It is more difficult to keep tiny children happy than it is their older brothers and sisters. Tiny tots can look at pictures, and the dime stores are full of interesting — and at the same time instructive — picture books. Little children always enjoy juvenile records and a new one will often keep them quiet for a long time. These are now inexpensive, and will fit on any record player. In our family — where the number of juvenile illnesses has been lengthy and numerous — we have always felt that the little (or middle-sized) invalid had a priority on both radio and record player if there wasn't one already in the room. When one of our children faced a six-months' period in bed, her grandparents presented her with a record player and one or two records. As time went on and others knew about the gift, a record appeared in the mail from time to time. I mention this as a suggestion that is well worth considering, for when a little sick-a-bed is uneasy a quiet musical number — such as Brahms Lullaby — will often turn a neat trick at eliminating tension.

Mrs. Bell resides in Tucson, Ariz.

For spry young children, a canary, parakeet, or bowl of goldfish will be eye and ear catching, help to make the sickroom cheery, and keep the child happy. In homes where a bird is a part of the domestic scene, it is an easy matter to move it to the child's room. Goldfish and globes are inexpensive and when placed on a table at eye-level for the flat-on-his-back child will keep him alert to the golden flashings through the clear water. Even fish-feeding time will be a diversion! The triangular glass prisms that make up the old-fashioned candelabra that most of our grandmothers had, are fascinating to a child. Carefully remove one from its hook and hang it by a stout thread in the window that gets the most sunshine. As the prism gently sways back and forth in the sunlight, the colorful and elusive "light-birds" will dart here and there on the wall, across the bed, sometimes on the child's eager hands.

Quite small children can handle the wooden beads used in kindergartens and made in the seven standard colors. One of our children learned his colors very quickly through these beads while having the fun of stringing them for his sister to wear. There are colorful design-blocks, too, which also teach color while the child is creating his own designs. And every mother knows how much little children like to "make things" from plasticine. For this task, be sure to cover the bed-table with a piece of plastic or oilcloth to avoid soiling the counterpane, for children can have just as much fun being neat while doing interesting things as they can making more work for mother!

No matter what the age of the child who is ill, some sort of bed table is necessary and if you don't have a *bona fide* one, substitute a card table. Stand two of the table legs on the floor close to the bed, leave the other two folded under the table and rest the opposite side on a firm pillow or blanket. If the table is a Formica-topped one you won't need to cover it;



if not, buy a square of sunny-yellow oilcloth and thumb-tack it on the under side to protect the table. It wipes off easily.

Slightly older girls will adore paper doll cutting and dressing, again materials that are obtainable at the dime store. Boys will have as much fun with the books that involve cutting out and assembling planes, jets, motors and the like. Scraps may be dropped into a waste basket beside the bed or into a laundry or large paper-bag pinned to the side. Tinker-toys are simple building pieces that both boys and girls enjoy, and scrapbooks are always popular. For the latter it is wise to give the little sick-a-bed an objective. Every town has a hospital or orphanage to which the finished book can go. Making a scrapbook as pretty and neat as possible, to be given one who is ill, has a sound psychological effect. The child thinks of someone else and ceases to be sorry for himself, if that has been his attitude.

Simple jigsaw puzzles are fun for all children. For the younger ones, the pieces should be large and the puzzle easy, to avoid frustration. Older children will enjoy the challenge of fitting map puzzles together, placing the countries, states, and provinces in the correct spots. A pleasant way to study geography!

"Picture stories" are fun to make. Give the child a pile of magazines of the type that are filled with colored advertisements and pictures of all kinds. By looking through them he will soon get ideas for making stories from the pictures, filling in a word here and there to make complete sentences. For example, many milk ads have a cow included, so: "*A cow gives milk and eats grass. Children drink milk.*" (The italicized words indicate easily found pictures.)

Older children enjoy making decorative stationery by cutting out flowers, fruit, a plane, a girl-or boy-head, then carefully pasting them to the top of dime-store note paper. This might serve as a future birthday gift for an older brother or sister. Then he can make some for himself upon which to write the important "thank you notes" to friends and relatives who have been nice to him while ill.

If the child has never had a diary, this is a good time to give him one for he will enjoy making entries each day, or night, and doing so will make him realize how fortunate he is to have a home, family and friends who are so kind to him. If he is at all good at making verses, suggest the entries be made in rhyme; this will take extra time since he will want to practice on paper before entering the verses in the "brand-new" diary.

Carving figures from pure white soap is a good idea if the invalid can actually do carving and won't simply "mess up" the bed, thus making extra work. By the trial and error system I know that children can do many things to keep them happy without causing mother extra work — a thing that shouldn't be allowed since illness itself causes extra work. In fact, many children will take pride in trying to save mother from extra steps by using a whistle, or mouth organ, to call her when she is needed. One blow, or toot, can mean "Come when you can," two "Please come now."

Growing things add to the attractiveness of a child's sickroom and the little sick-a-bed can plant a carrot, or sweet potato, in a vase, then watch it grow. One child I know planted six sweet potatoes in cheap vases and when they were at a pretty, green-leaved stage, asked her older brother to deliver them to six people she knew who would enjoy them. Two were other children who happened to be in bed with the mumps and a bad cold, three were older people on the same street, and one was her beloved grandmother.

Mothers should remember that long illnesses *can* bring out selfishness in a child. For that reason the more things that can be done to divert the interest to *others* the better the therapy. Other family members will naturally play Scrabble, Old Maid, Canasta, Parchesi, or whatever the age-level and interest of the child is. But he must not be allowed to feel that he should always accept their offers or he may get to expect too much attention. This is sometimes difficult for a parent to do, but the child will be thankful for this treatment later — you may be sure of that!

# What about Vacation Plans?

ETHEL ARMSTRONG COLLINS

WHEN THE CONVENTION IS OVER, give yourself a holiday! Post-convention trips are becoming increasingly popular, and deservedly so. Nurses, of all persons, realize that a vacation is not an expense but an investment, paying dividends in health, happiness, new friendships and memories. Go East or West, north to the rim of the Arctic Circle, to the land beyond the sunset, or down to the South Pacific. See the majestic Canadian Rockies, Banff Springs; incomparable Lake Louise; Jasper Park; Mount Edith Cavell; the Pacific Coast. Sail across the Straits of Georgia to Victoria, stop at the lovely, old, ivy-covered Empress Hotel. See the famous Butchart Gardens and go over the Malahat Drive. Cruise to Alaska or fly to the southern paradise of Hawaii. Or visit the big cities of the East — Ottawa, the Nation's capital; Toronto, Niagara

Falls, Quebec and Montreal. Take an inland cruise down the mighty St. Lawrence and up the Saguenay River. The choice is your own. Make it a happy one and have a never-to-be-forgotten holiday. This is not just wishful thinking — all of these trips have been planned and worked out for your pleasure and comfort *and* at reasonable cost! They can all be done within the thirty day return limit on your convention fare to Winnipeg.

Fairly complete information about these trips was published in the October issue of *The Canadian Nurse*, but it has been necessary to make some changes. The Canadian Pacific Airlines have advised us with regret that they will not be operating the Klondyke Gold Nugget Tour in 1956. The Canadian National Railways have made some changes in the Alaska Cruise. It is now proposed that the T.S.S. *Prince George* will leave Vancouver Wednesday, July 4 at 9:00 p.m., sail up the Inside Passage, make the usual calls at Prince Rupert, Ketch-

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Mrs. Collins is Convention Coordinator of the Canadian Nurses' Association, Ottawa, Ontario.



(C.P.R. Photo)

*Administration Building, University of Manitoba.*



ikan and Juneau, and arrive in Skagway Sunday morning at eight o'clock. Instead of remaining in port for 36 hours, as formerly, it will stay only 12, therefore both the West Taku Arm and the Whitehorse Trips must be cancelled. A scenic tour will leave Skagway at 8:30 a.m. for Carcross, over the historic Trail of '98. There will be a stopover at Bennett, and return to the ship at 4:15 p.m. in time for the 7:00 p.m. sailing. Arrive back in Vancouver July 13 at 9:00 a.m.

Those taking the Hawaiian Tour may leave Winnipeg Saturday afternoon, June 30, on a T.C.A. tourist flight, arriving at Vancouver that same evening. The Canadian Pacific Empress Airliner takes off at two o'clock Sunday afternoon for Honolulu, where it arrives at 11:30 p.m. Instead of the Moana Hotel as previously planned, our party will stay at the Halekulani (meaning "House befitting Heaven"). Located in a four-acre cocoanut grove on the beach at Waikiki, it is one of the beauty spots of the Island, where one may enjoy all the comforts of a modern hotel in a delightful setting, typical of old Hawaii. Guests are welcomed with the traditional leis of orchids, ginger flowers or frangipani, and a friendly holiday atmosphere prevails. There is Hawaiian entertainment — dances, music and native feasts — once a week there is a special festival of ancient and modern hula at a colorful buffet luncheon on the Ocean Terrace. The swimming is unsurpassed anywhere in the world. Average water temperature in July is 81°; average air temperature 76°. Step right off the terrace on to the Beach, to sun or swim — to try the thrill of surfing (with an expert instructor), or the excitement of riding the waves in a catamaran or outrigger canoe.

People whose way of living has not changed for many centuries are free of certain diseases that take many lives in modern countries. For example, of 80,000 Jews who emigrated from the ancient land of Yemen to Israel, researchers found that not one had diabetes, or other degenerative diseases. The scientists were struck by the fact that there was no hardening of the arteries even among those over 45 — the age when other peoples begin to suffer

Four sightseeing tours are included in the cost of your trip to Hawaii. Limousines are used and the drivers are friendly hosts as well as informed guides. The *City Tour* takes you into the palace of former kings, with the Throne Room still intact, also to the residence of the late Queen Lilioukalani and to Moanalau Park. The *Circle Island Tour*, through pineapple plantations, sugar cane fields and acres of orchids, includes visits to a Buddhist Temple, a Mormon Temple, the Oahu Country Club, Upside Down Falls, and a poi factory, to mention a few points of interest. The *Koko Head Tour* follows a winding drive along the sea coast, past the Amelia Earhart Memorial, Diamond Head, Koko crater, an extinct volcano, and the Blow Hole. The *Mount Tantalus Tour* gives a breath-taking panoramic view of Honolulu, Pearl Harbor and miles of surrounding countryside. This trip includes tea at the old Waiola Tea-room and a visit to Robert Louis Stevenson's Grass Shack. There are many other sightseeing trips that can be taken if one desires, also there are daily flights across to other islands.

Certainly it provides a wonderful holiday with never a dull moment. As one member of our party expressed it in 1954, "No matter what happens now, I have been in Paradise." Wearing many leis, we will say a sad "Aloha" to the Friendly Islands, and board our plane on Thursday evening July 12, arriving back in Vancouver Friday morning.

Because these tours come at the height of the busy summer season, may we urge you to *please get your reservations in early*. Also, from recent experience we are reminded that **PRICES AND TIMES ARE SUBJECT TO CHANGE**.

heavily from this disease.

A special study was made of 300 immigrants, all over 45. Their bodies were free of cholesterol, a chemical regarded as the primary cause of hardening of the arteries. After two years in Israel, the cholesterol levels in their bodies rose but remained lower than those found in western peoples. And there was still no sign of degeneration of their arteries or other organs.

— (ISPS)



# In Memoriam

**Elizabeth Jane Bowlie**, a graduate of Lady Stanley Institute, Ottawa, died suddenly October 26, 1955. Miss Bowlie served with the C.A.M.C. during World War 1. Following her release from the service she worked in Kingston, and later was on the staff of Ste. Anne's Military Hospital, Ste. Anne de Bellevue, Que.

\* \* \*

**Edith Grace (Bishop) Clark** who graduated from Prince Edward Island Hospital, Charlottetown, in 1926, died at her home in Tarryburn, N.B., on October 28, 1955, after a lengthy illness. For many years she worked at the New Rochelle and Wick-ersham Hospitals, N.Y., before engaging in private nursing at the Saint John General Hospital, N.B.

\* \* \*

**Jean Cormie**, a graduate of Oshawa General Hospital, passed away at her home in Fergus, Ont., on October 12, 1955.

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**Patricia (Bazanet) Farrell** who graduated in 1946 from St. Michael's Hospital, Toronto, died there on June 24, 1955.

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**Ella Forbes**, formerly a resident of Nova Scotia, died in October, 1955, at Gimli, Manitoba.

\* \* \*

**Evelyn Elizabeth (Gouldie) Hawke** who graduated from Women's College Hospital, Toronto in 1939, died in November, 1955. Mrs. Hawke was with the Sangamo Co. Ltd. as plant nurse for ten years.

\* \* \*

**Cynthia Pauline Horsnell**, a graduate of Victoria General Hospital, Halifax, died at Berwick, N.S. in November, 1955. Miss Horsnell served on the staffs of Fraser Memorial Hospital, Kentville and Highland View Hospital, Amherst. Later she was supervisor of the nursery at Grace Hospital, Ottawa. Prior to her illness Miss Horsnell was on the staff of Stratford Hospital, Ont.

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**Lucille Laura (Ross) Stanley-Jones**, formerly of Seaforth, Delaware, died in Vancouver, November 16, 1955. During World War 1, Mrs. Stanley-Jones served as a nursing sister with the French Red Cross Society.

**Jemina Leckie**, a graduate of Mount Clair General Hospital, New Jersey, died at London, Ont., on October 29, 1955. She worked a number of years at the Delaware Water Gap Sanitarium and later nursed in Detroit, Toronto, Goderich and London. At the time of her retirement she was matron of the Belleville nurses' home in New Jersey. She was 90 years of age.

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**Daisy (Grant) MacIntosh**, a graduate of an American Hospital died suddenly at Stellarton, N.S. on November 13, 1955.

\* \* \*

**Margaret McDermid** died on October 31, 1955, at London, Ont. Miss McDermid helped to organize the first public health nursing course at the University of Western Ontario.

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**Bernadette (Walsh) McDermott**, who graduated from St. Michael's Hospital, Toronto, in 1919, died there on October 4, 1955. For some time she engaged in public health work and private nursing.

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**Rose (Kemmet) McDonald**, who graduated from St. Michael's Hospital, Toronto in 1905, died in that city on July 28, 1955. Prior to her marriage she was engaged in public health nursing.

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**Margaret Elizabeth (Hunter) Pedlow**, who graduated from the Royal Victoria Hospital, Montreal, in 1947, died in Vancouver on November 9, 1955. She was 32 years old.

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**Kathleen H. Walker**, who graduated from St. Joseph's Hospital, Toronto in 1930, died suddenly at her home in Islington, Ont., on November 1, 1955. Miss Walker had done staff nursing for 10 years before assuming the position of supervisor of public health nurses in York Township.

\* \* \*

**Caroline (Kennedy) Watts**, who graduated from a Winnipeg hospital in 1897, died in Nelson, B.C., at the age of 94. At one time she served as matron of Kootenay Lake General Hospital and performed outstanding nursing work during the influenza epidemic of 1918.

L'éducation consiste dans la croissance, le développement de l'être humain jusqu'à l'état

parfait d'homme comme tel, qui est l'état de vertu.  
— ST. THOMAS D'AQUIN

# NURSING SERVICE

## The Role of the Industrial Nurse in Accident Prevention

THERESA GREVILLE

NURSING, IN GENERAL, tends to be associated in the minds of most people with a smiling patient in a nice, neat bed with an attractive nurse (preferably red-haired) standing by... or, the more dramatic shots of men and women in white, gowned and masked, cheating death in an operating room.

The industrial age and the tempo of our times, combined with increased knowledge of disease prevention, have brought medical and nursing teams into every aspect of living and working. In addition to all of the work done in hospitals we have public health nurses, nurses in every branch of the Armed Services, nurses in the sky and more recently parachute rescue teams with Para Nurses.

Occupational nursing, a branch of public health nursing, "is the application of nursing skill to groups of men and women at their place of work for the purpose of helping them build and maintain their best health and to render prompt, efficient nursing assistance when they are ill or injured at work." (McGrath)

The ideal nurse for this work is one who has a willingness to continue her education throughout her working life. She should have a mature personality with a knowledge of psychology and a liking for working people. She should know or learn something about compensation laws, union agreements, hospitalization and medical plans as

they affect the place where she works. She should be aware of community resources available in matters of health and welfare. She needs to be prepared to render first aid and have special ability, judgment and knowledge so that she will route patients to the hospital, clinic or doctor, when necessary. She needs to know her role in disease prevention and the correct maintenance of records.

The first known literature on occupational diseases was published about 1703 by an Italian doctor, Bernardino Romanizi. Since that time and particularly since about 1890, occupational health has been of prime concern to governments, medical men, nurses, employers and employees. Nurses in industry have ferreted out the needs and with the assistance of the groups concerned, the "sanitation of the environment" has been improved.

### THE SAFETY PROGRAM

Accident prevention has become increasingly important to the nurse. In the *Journal of Chartered Insurance Institute*, published in England, there is a report by T. A. M. Pirrie in which he says:

There are two main reasons why accidents should be prevented: They cause suffering; they cause material waste.

The amount paid to the injured person is only part of the financial loss. The services of the man have been lost which often means that a new man has to be engaged and trained. If the injured man was skilled, it may be difficult to

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replace him. It may be necessary to shut down machinery so that an investigation may be held. Men in other parts of the plant lose time discussing the accident. Employees who saw it may be shocked and their work suffers accordingly. In short, the effects of an accident on production can go on being felt for a long time after it happens.

Management is not hard to convince of the importance of accident prevention. It is often the foreman and charge hand who have come up through the ranks who fail to grasp the importance of safety work. Those in charge of departments must be made to realize the responsibility that rests on them, and clearly understand that they are judged not only on the output of work but also on freedom from accidents. The foreman in turn needs the cooperation of all the employees in working safely and pointing up danger areas. An operator can become so familiar with his machine that he sees no danger in its working parts. Yet there are avoidable accidents that have resulted in heavy financial loss to the firm and worse than financial loss to the victims, for who can put a price on human life and limb? No one has yet discovered how to grow a new arm or hand and plastic surgery cannot completely cover up the scars. Surely it is up to us to protect industry's most valuable asset — the man on the job.

How does the nurse assist in the accident prevention program?

By an awareness of the goals of safety committees, and by cooperating with them to bring hazards and job complaints, as they relate to safety, to their attention.

By the day by day instruction of patients reporting to her, teaching each one the importance of preventing infection and disability by prompt attention to and follow-up care of minor injuries and illnesses. Other forms of instruction include reaching people through the plant magazine, bulletin boards and health literature racks.

By allaying apprehension. Rehabilitation starts with the first treatment. The nurse's attitude, while being realistic, must allay all fears as far as possible.

By recognizing emotional or physical disabilities that may lead to accidents

unless corrected; by realizing that certain conditions and diseases, such as those caused by alcohol, poisons, virus or bacterial infection, dietary deficiency, Parkinson's disease, multiple sclerosis, are fairly common. People suffering from them do not have proper physical control of themselves and are liable to more accidents than physically normal people. The employee suffering from such disorders should be referred for medical care and, with as little mental disturbance as possible, be made to realize that because of his handicap he must exercise more caution.

By realizing the effects of fatigue, whether caused by sleeplessness — T.V., broadcasts of games, the noise of planes or diesel engines — by the second job, skylarking, or the emotional strain due to sickness, discord or financial difficulties in the home.

She should work towards good personnel relationships. Dr. P. J. Moorad, U.S. Consultant in Psychiatry, writing in *Industrial Health*, about Human Factors in Accident Liability, states that "A new employee is often introduced to his job and department by unfavorable comments and fearful stories about his work. He is, therefore, psychologically predisposed to accidents. There is too much fooling around in industry, too much picking on the weak. There are more practical jokesters than supervisors and management realize. These are not healthy situations. The sensitive are constantly ill at ease, tense and anxious as to what will be done to them next. With a man's mind so taken up with irritation and annoyance by men around him, he cannot be a safe worker." The doctor recommends that practical jokesters, bullies and wise guys be exposed and dealt with as a plant responsibility in the interest of health and safety.

The nurse should probably not head up the Safety Committee because participation in safety work brings education to a greater number of workers either at the supervisory or unskilled level, but, she should participate in all ways possible to further the work of such committees and so create a happy and healthy work situation for all workers from the executive of the company to every member of the work team.



# Schizophrenia

ANN STEWART

## INTRODUCTION OF PROBLEM

JUDY ARRIVED at the Allan Memorial Institute one Sunday evening, escorted by two policemen. She was an attractive fifteen-year old, neatly dressed in slacks and a raincoat. She had applied her make-up with a generous if slightly unskilled hand. She showed no outward sign of her recent bizarre behavior.

When she was shown to her room on the ward, she quickly lay down on the bed assigned to her. Her eyes were wide and staring, her face devoid of expression. Although she appeared mute, she seemed to be well aware of her immediate surroundings. She lay with her head extended in an awkward, seemingly painful position and soon became irritable and moderately negativistic to the doctor's insistent questioning. That evening, she appeared ill at ease in the company of the other patients in the room and remained unresponsive to their friendly approaches.

It is of interest to note that, although she had seemed, to her parents, to be behaving in a very peculiar manner for the previous week, they had left her in the company of an older sister for the week-end. It was while they were absent that she was found wandering about the streets by the police.

## PHYSICAL CONDITION

My patient, the seventh youngest of eight siblings, had been a premature baby. Her mother, a plump, middle-aged woman did not have a difficult delivery. Before the age of one, the patient had struggled through four

consecutive bouts of pneumonia, but she seemed to progress fairly well after her first year and measles was her only other childhood disease. Excepting for removal of tonsils she had never had any operation, accidents or peculiar habits.

Judy was a slight but wiry adolescent who weighed 90 pounds on admission and stood five feet, three inches tall. She had been known to complain of her flat-chested condition to her mother and sisters, and was quite indignant that her clothes did not fit so well as other girls. She frequently complained of headache during the year prior to coming to hospital. Although there was no definite evidence of hallucinations or delusions, she was quite openly apathetic, listless and displayed indifference that passed into mute catatonic states fairly readily. As previously mentioned she was often irritable and negativistic.

About a week following her admission, she complained of pain just below her right ear and was seen by the doctor who assured her that there was nothing there to worry about. During visiting hours, she was very demanding of attention from her parents and later while sitting at the supper table suddenly began to cry "Oh my head!" and to extend her head in an awkward, crooked position.

She rushed to her room, insisted on seeing her doctor again and attempted to leave the building when he didn't arrive immediately. When he came she appeared mute and hostile, but seemed slightly reassured. Eventually she was persuaded to eat her supper and to participate in the ward's evening activities to a small degree. Although no further mention was made of this particular discomfort, there have been other episodes when the complaints have been headache, constipation, earache or abdominal cramps. Each time she was carefully examined by the doctor, but nothing was discovered.

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Miss Stewart, who graduated in 1955 from Royal Victoria Hospital, Montreal, prepared this study while on affiliation at the Allan Memorial Institute.

Judy recently entered high school. Bilingual and generally first in her class, she had not been allowed as a small child to play with her friends anywhere excepting on the balcony of her own home. When these restrictions were relaxed my patient formed many new friendships. Her mother described Judy as enjoying the company of her many schoolmates and she seemed to socialize easily.

Her father was a slightly-built man of medium height. Superficially he seemed meek and timid, acting sheepishly in the company of strangers. When he was visiting his daughter he never spoke while the nurse was in the room. This unfortunate man has an intense fear of dying or even suffering the slightest physical injury.

In contrast her mother was an anxious, concerned, middle-aged woman. Due to her unhappy, impoverished home life, she has suffered several mild depressions, but she constantly tried to bring about peace in the distraught household. One brother, 18 years old, has recently come under psychiatric treatment.

Her mother described Judy's behavior, particularly in the past year, as erratic, irritable and highlighted by frequent outbursts of temper. She would suddenly demand something — very frequently new clothes — and would fly into a fit of anger if her whim was not indulged immediately. Intensely jealous of her now happily married older sister, throughout the sister's courtship, Judy would become violent and throw articles about the room. She insisted she wanted the living room to herself whenever her sister was visited by her fiancé. Actually, Judy was quite shy and ill at ease with boys and said she has an aversion towards them.

Judy had always shown a fanatical desire for new clothes and was jealous of her older, working sister who was able to have a larger wardrobe. She spent considerable time getting dressed and applying make-up, gazing all the while at her reflection in the mirror. She felt she was built more like her father, would have liked to appear older than her age and wondered why she

did not look like her young friends who were better proportioned than she. This feeling of awkwardness and self-consciousness might easily be due to her age. Fifteen is a time for personal misgivings on the part of any youth.

This family was Roman Catholic but my patient did not seem particularly devout. There were no medals or prayer books in her belongings at the hospital and she never, to my knowledge, asked to see her priest on her own initiative.

It became evident that Judy was having difficulty in school, where previously she had done well. Feeling that her teacher and the students were laughing at her, she tended to isolate and seclude herself. Finally she absolutely refused to attend school, stating she wanted to punish her parents. Until the time of her admission, her behavior went steadily downhill. There was open withdrawal of interest in her schoolmates, loss of ambition in her school work and indication of obvious feeling, thinking and behavior disorders. Frequently she would insult her mother and sisters with coarse, vulgar expressions then suddenly turn and kiss them, begging their pardon. These outbursts were most apparent preceding and during her menstrual periods which had been fairly regular since their onset several years before. Inconsistently, she would refuse what was given to her, although she had previously asked for it. She would take what was not hers, threatening suicide if her wishes were not granted.

The Thursday prior to her admission, Judy stayed in bed, refusing to eat. At four o'clock in the morning she attempted to leave the house, crying "Nobody loves me, nobody wants me." She hit and kicked her mother, who tried to calm her. Eventually she returned to bed where she slept all through the next day.

#### SUPPORTIVE CARE

**Nutrition:** This was a major problem with Judy, particularly when she was put on coma insulin and it was imperative that she have a well-bal-



anced diet. Constant encouragement and persuasion were required to bring her to the dining room, where she would sit and stare disdainfully at her food. She enjoyed fluids, particularly tea, but her appetite after her treatment was exceptionally poor. The family, with obviously good intentions, brought her fruit, candy and cookies, but these were put aside and soon forgotten.

### ***How We Attempted to Overcome This Problem:***

a. Throughout the earlier part of the day, after the coma insulin therapy, we offered frequent small meals. This was the schedule:

10:30 a.m. — (or at the time of completion of treatment) fruit juice, toast and jam, tea.

12:00 a.m. — a meat sandwich and milk.

2:30 p.m. — ice cream, fruit juice.

5:00 p.m. — supper with the other patients.

8:30 p.m. — milk and sandwiches.

b. The confections brought by her mother were kept in Judy's refrigerator and offered to her after a meal so that they would not spoil her appetite.

c. We tried to avoid hurrying Judy either to come to meals or to eat, in an attempt to overcome the tension which inhibits the appetite and delays digestion. To do this, I would approach her about 15 minutes before the meal was to be served, giving her ample time to apply make-up and care for her hair, then walk in a leisurely manner to the dining room.

d. Frequently the nurse on duty would use power of suggestion — for example, the sight and odor of food; leaving the food in an accessible place without comment after placing a spoon in her hand.

e. If possible, we placed Judy at a table where her companions ate at a leisurely pace and it was unnecessary for her to compete with faster-eating people.

f. We tried not to fuss over her too much, at the same time we did not allow her to dawdle over her meals long after everyone else had finished.

***Sleep:*** The difficulty here was

Judy's desire to withdraw from the environment. She would remain in bed all day if left to herself. We encouraged her to be about during the day so that she would sleep well at night. She seldom required evening sedation.

### ***How We Went About This Problem:***

a. We tried to keep her out of her room as much as possible. As soon as she had finished her meal, we asked her to join us while we watched T.V. or participated in some ward activity. The suggestion of occupational therapy sometimes was effective. She sometimes spent the afternoon sewing.

b. A walk out of doors proved to be refreshing and invigorating.

c. It was essential that the nurses worked as a team, encouraging her and preventing her from slipping away from being with others.

***Personal Hygiene:*** My patient, unable to always sense her physical needs due to her slowed-down mental state, depended in part on the nurse for personal cleanliness and appearance. Such particulars had to be cared for without making her feel conspicuous. If the results drew some expression of approval from the other patients and nurses, it was a good tonic for her.

### ***How We Attempted to Approach This Matter:***

a. After her treatment in the morning, we prepared a bath or shower to freshen and brighten her. Brisk rubbing with coarse bath towels aided in stimulating circulation. Having been generously supplied with bath powder and deodorant by her family, these articles were laid out for her and she applied them daily.

b. Laying out her tooth paste and brush generally was sufficient reminder to care for her teeth; if not, putting the tooth paste on her brush served to guide her. I usually left a plastic glass by the sink and offered a glass of water to her whenever I was in the room. A glass of mouthwash, offered before her meal, relieved any sour taste present in her mouth.



c. We tried to encourage her to go to the bathroom at regular intervals. She generally had a bowel movement about every second day, but was inclined to be negligent about her regularity. Offering fruits throughout the day, as well as some sort of daily exercise, helped her overcome this problem.

d. As an adolescent, she had the usual troubles with her complexion. Her skin was quite oily so it was important to remind her to wash her face with soap and water frequently. Applying cold cream to her lips, which were often cracked or chapped, softened them considerably. Reminding her at bedtime to remove her cosmetics and wash her face was helpful. Although she loved to look at herself in the mirror, she frequently forgot to care for herself.

e. We tried to encourage her to keep her comb and brush clean. Since she washed her hair every weekend while she was at home, it was a simple matter to care for it during the week. She arranged the short, naturally curly hair very attractively with some assistance.

f. Laying out her emory board and nail file on her dresser after her morning bath taught her to care for her nails.

g. We noted the duration and flow of her menses. We offered her the sanitary pads on the ward and assisted her in local cleanliness and sanitation if she required help.

h. Since she loved clothes, particularly new ones, we guided her in the care of her personal articles. It was important for the nurses to cooperate with each other in developing Judy's interest in her personal hygiene and teaching her hygienic procedures whenever the opportunity arose. We helped raise her self-respect by a well-placed compliment, our own personal example and expressing admiration of the good hygiene carried out by other patients or nurses.

#### PROTECTIVE CARE

**Suicide:** Although I realize that anyone emotionally upset is potentially suicidal and that my patient had threatened on several occasions before she came to hospital to end her life, I believe that it was done to attract attention and to punish her parents.

During her hospital stay it was more of a problem to prevent her leaving without permission. She did not threaten or attempt suicide, to my knowledge, while here. The precautions that we took to avoid injury to the patient were the same as for prevention of suicide.

It is to be noted that the physical environment of the hospital offers the security that is one of the patient's greatest needs. Security that can be depended upon, a routine that is reasonably the same from day to day, contact with a limited number of persons, removal from significant persons who have been the cause of some of their difficulties, relieve patients of the necessity of making decisions and of the many demands of usual existence.

#### *Injury to Herself and to Others:*

Several days after admission, Judy while taking a shower turned on the hot water faucet too swiftly and as a result received a bad scare. Luckily she was not burned. It was a blunt reminder to the staff that this little girl needed keener surveillance.

#### *Precautionary Methods to Prevent Injury:*

a. On admission we routinely check through all the patient's belongings. Any sharp things are kept in the office, to be given to the patient if required for a short period of time and then returned to the office. Matches are kept only by the nurses and the patients are not allowed to smoke in their rooms. It is helpful to remind the relatives that the patients are not allowed to retain these articles while in hospital.

b. After coma insulin treatment, Judy was unsteady on her feet, requiring staff assistance to prevent her from bumping into furniture or tripping over objects. We ran her bath or shower for her and were nearby in case she required help.

c. Hazards such as waxed or wet floors can be treacherous to a preoccupied patient, so we guided her around those obstacles.

d. Laundry chutes, kitchens, bathrooms except in the morning were kept locked as well as the utility room, linen

room and nurses' office with all the medical supplies. The doors at either end of the ward were kept locked at night. No cutlery or glassware was allowed in the rooms. The windows open only a few inches from the bottom.

e. If Judy was too strongly antagonized by some well-meaning, but thoughtless patient, she might easily have acted impulsively and hurt this person. She also needed protection, both physically and psychologically, from other more aggressive patients. It was wise for the nurse to anticipate such occurrence and to be on the alert for any impulsive and un-self-disciplined act.

### *Leaving Without Permission:*

Judy made several attempts to run away. When her hostile, negativistic manner was more emphasized than usual it was a danger signal to the staff.

### *How We Prevented These Incidents from Occurring:*

a. By being alert to recognize her increased hostility, thus anticipating her desire to leave.

b. Judy was both insecure and uncertain so that one of the most effective measures to promote a sense of security was consistency in the nurse's attitude. A routine was offered that gave her something to depend upon. Thus we avoided making promises to her that we knew could not be carried out — e.g. a promised visit home that did not materialize.

c. On her admission to hospital, the various privileges and limitations were explained to her. At the patients' group meetings the head nurse frequently gave a reminder of the precautionary rules of the hospital — e.g. boundaries of the hospital grounds.

d. Reporting accurately and promptly to the head nurse or interne, both orally and on the chart, any unwarranted change in the patient's conduct.

## SOCIAL

**Socialization:** The tendency of patients to withdraw into a world of phantasy from situations where they must socialize is very persistent. Per-

haps Judy felt that her contacts with other people had been fruitless, her family and friends had let her down or just did not understand her. Obviously she was so preoccupied at times, we knew she was not giving us her attention. When we spoke to her she might or might not respond.

### *How to Counteract This Problem:*

a. The nurse must be consistent in her attitude — friendly, but firm, realizing that it is her responsibility to bring her patient into contact with everyday living.

b. Since in her preoccupation, Judy might respond to our approach with irritation, we must realize that we have probably diverted her attention from something that was pleasant to something that was annoying. I tried to circumvent Judy's irritation by appealing to her suggestibility. For example, laying her clothes out on her bed so she would dress and be prepared for the day at the same time as the other patients. We also avoided her antagonism by seldom touching and never pushing her about.

c. Since most people like to be warned about what to expect in a new situation, it was important to explain new procedures to her as well as to introduce her to a new roommate.

d. My seeking out of this patient at every opportunity conveyed my interest to her. Just sitting quietly beside her for brief, but consistent periods conveyed this message. There were many one-sided conversations, generalizations that did not require answers. Eventually one could feel her warming to sympathy and she would offer a comment of her own.

e. Due to the coma insulin therapy she received, she was only able to be at occupational therapy in the afternoon. After strong persuasion from the staff and friendly patients she started and took obvious delight in making a pink felt elephant. Later the staff was unable to encourage her to attempt something else.

Judy seldom conversed with other patients. Her uneasiness on the night of her admission had been reduced to a mere apathetic interest. Generally it

was only after a weekend at home that we might see her coming to watch television on her own initiative, or perhaps share a few words with someone.

**Observation:** The extent of the patient's progress is often shown by the nurse's observations, carried out in a manner that will cause the patient no discomfort or concern.

### **Direct Observation:**

a. Notice the patient's facial expression, this may often correspond to her emotions.

b. Note whether her mood is appropriate to the situation or is consistent with her behavior.

c. Observe her movements and choice of activity.

d. Note how she adapts to the environment — is her manner indifferent? Does she identify others accurately and indicate that she knows what day, time and place it is?

e. Describe her daily habits — personal hygiene, care of personal property, appearance, industry. Note any bizarre, unusual behavior. If she has been mute for a long period, then relate the circumstances that lead up to her breaking her silence.

f. Describe her speech, the expression of feeling, any memory defect.

g. Note her choice of companions. Does she frequently demand to see the doctor, refusing the nurse's assistance?

### **Observation by Participation:**

Frequently I dropped by the occupational therapy department and chatted with the patients and therapists, at the same time, observing my patient for:

a. Extent of pleasure and enthusiasm in work.

b. Expression on her face — did she seem engrossed in her work? Did she seem contented or bored?

c. Her ability to do the work — did she seem to take pride in her handiwork?

d. Did she concentrate well?

e. Was she there of her own accord? Did she soon show signs of fatigue?

f. Had her ability improved since her last visit to occupational therapy?

g. In order to observe my patient's appetite, I could assist in the dining room without making the patients feel uncomfortable — helping to seat them, pouring milk and tea, passing cream and sugar and anticipating special requests. I noted my patient's manners and her consideration for others at the same table. Did she eat her food in the regular order? Did she socialize at all or concentrate all her efforts on eating?

h. By playing a card game or working a jigsaw puzzle with my patient, I would note: her ability to play fair — was she a good sport or a poor loser? What of her ability to learn new games — her confidence in herself?

i. How did she behave when her family visited her? What were her feelings before and after their visit? Did she seem to enjoy their company?

j. Her behavior throughout any treatments.

### **Rehabilitation:**

It is rather unusual to note that according to her parent's description, when Judy was allowed to go home she socialized quite readily and entered with enthusiasm into the home duties such as baking or sewing. While she was at hospital her seclusiveness and negativism continued to be quite evident. It appeared that her condition improved considerably when she was in the home atmosphere.

As a nurse, I tried to adopt a teaching pattern for helping my patient prepare for her eventual return home. I carried out this plan by:

a. Offering a stimulating environment for the learning of new skills. Association of the patient with her roommates who were on the same treatment as herself, offering new recipes for cooking which she enjoyed doing at home, and reading fashion magazines, were ways to interest her.

b. By my example my patient might learn a great deal. I had to keep in mind that my appearance, manner and attitude might be beneficial or harmful.

c. Repetition of new ideas and skills until they were firmly fixed in her mind.

d. Above all the reassurance of an understanding nurse, interest in her as a person, attention to matters that are important to her helped her attain her



goal. Attention was focussed on the value of day-to-day experience, acquirement of good health habits, including a balanced program of work and play. It must be remembered that she was a young girl who became ill during her adolescence, never a very easy time for anyone. She will require the guidance and counsel of her parents, doctors, nurses and teachers to prepare her to lead a normal life.

### PROGNOSIS AND FUTURE PLANS

Although Judy's improvement was not very startling, her parents felt that while she was at home she was perfectly normal and quite able to resume her normal activities without hesitation. They believed that our doc-

tors were being fooled by her attitude in hospital. In the doctor's words, "she was suffering from a very serious illness, coming on at a critical time in her life and that unless she had the full course of therapy, it was unlikely she would remain out of hospital for prolonged periods of her life."

### WHAT I HAVE GAINED

Through this study of Judy and by the nursing care I gave her, I have gained insight into psychiatric nursing. Now I realize what the words "persuasion" and "patience" mean in relation to a preoccupied and hostile adolescent. Perhaps it has helped me understand myself a little better, my limitations, and my way of solving conflicts.

## Cavernous Sinus Thrombosis

C. LAWTON AND M. HOBIN

**T**HE PATIENT WAS 20 years of age, and had been a normal, healthy girl until one day she developed a sore, infected spot in her nose. Nothing was done about this as it appeared only a mild ailment.

The following day the girl complained of dizziness, nausea and general malaise. She was found to have a temperature of 102°F. She went to bed and was given an injection of

penicillin by a relative who was a graduate nurse. Her condition gradually became worse so the following day a doctor was called and she was admitted to hospital.

On admission the patient was vague and drowsy, but extremely restless and showed definite signs of profound toxemia. Her face was discolored with protosis in both eyes.

A complete blood count revealed:

White blood cells 30,800

Hemoglobin 72%

Red blood cells 3,800,000

A spinal tap showed:

White blood cells 912

Red blood cells 22

Pandy's positive

Cultures sterile.

A nose culture showed:

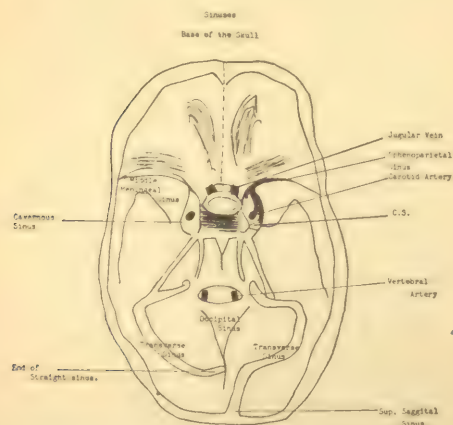
Gram positive cocci, moderate growth

*Staphylococcus aureus*

Coagulase positive.

She was sensitive to Chloromycetin, less sensitive to Penicillin.

By 8:00 p.m. the patient was semi-conscious — temperature 105°, pulse



*Cross-section of the base of the skull showing sinuses*

100, respirations 20. A cold water enema was given and cold packs applied continuously. These succeeded only in reducing the temperature temporarily, and were discontinued two hours later when the patient's temperature returned to 105° and she commenced to have chills.

10:30 p.m.: She was very cyanosed and was placed in an oxygen tent. The pulse was rapid and of weak volume, respirations shallow, and her face now appeared more swollen and red. She did not respond to stimuli. An airway was inserted and suctioned as necessary.

6:30 a.m.: The patient was completely unconscious.

9:30 a.m.: A tracheotomy was performed as a precautionary measure against tracheal edema, respirations appeared a little easier on return to her room. Very little change was noted during the next few hours, although the temperature dropped to 100°, pulse 112, respirations 28.

6:00 p.m.: The patient's pulse became much weaker, color extremely poor and respirations shallow.

Despite a rigorous course of antibiotics, which we will now outline for you, the patient died at 7:35 p.m. three days after the infection first appeared in her nose.

#### MEDICATIONS AND TREATMENTS

Immediately on admission an intravenous of glucose 5% was commenced and kept running continuously. The following were given by means of the intravenous:

- Sulphadiazine gm.4.0 stat. and gm.2.0 q. 6 h.
- Aureomycin 500 mgm. q. 4 h.
- Chloromycetin gm. 0.5 for 2 doses
- Ilotycin gm. 1.

Heparin was also given and doses adjusted according to the clotting time which was taken q. 3 h.

Three spinal taps were performed and each time one million units of penicillin and streptomycin 900 mgm. were injected intrathecally.

Penicillin 1 million units was given q. 2 h. intramuscularly and streptomycin 500 mgm. q. 6 h.

It was suggested that Cortone might help to relieve cerebral edema and so 100 mgm. was given intramuscularly into each hip.

When the condition of the patient worsened coramine 5 cc. was injected intravenously every 15 minutes, with only temporary response.

#### SUMMARY OF AUTOPSY

The findings are those of infection of the nose, and edema of the nose, eyelids, and upper lids, with thrombosis of the left cavernous sinus, involving the circular sinus and the right cavernous sinus, with extension to the middle cerebral veins, superior petrosal veins, and the pterygoid veins, with infection, compression, and edema of the upper part of the mid-brain, and the extension of the infection into the basi-sphenoid and the embolic spread down to the jugular veins to the lungs where there were numerous abscesses.

The cultures taken prior to death, and the areas examined after death have all grown coagulase positive staphylococci in pure culture.

#### CAUSE OF DEATH

Brain stem damage, due to thrombosis of both cavernous sinuses following an infection of the nose with subsequent pyemia to the lungs.

## Check Points for Canned Food Buyers

Government supervised grade marks on all canned goods are the first thing to watch for when making a selection. Buy nationally advertised brands unless you are familiar with particular smaller companies. Other check points are:

1. Avoid containers that show dampness, drippings, rust and bulging ends.
2. Listen for sizzling sounds of escaping

air when first puncturing the can.

3. Take a deep smell for characteristic aroma immediately on opening container.

4. Drain contents and observe inside of container for color. Darkened can indicates long storage.

5. Taste for characteristic flavor and added ingredients.

— *Canadian Hotel Review and Restaurant*

# NURSING EDUCATION

## With our Training We can Help

EMILY GROENEWALD

THE PATIENTS ON WARD X, all of them ambulatory, were neglecting their customary morning activities. Usually one or two would be pondering over an unfinished jigsaw puzzle. Another might be putting the finishing touches on a leather wallet, inwardly glowing at the thought of the pleased surprise of the occupational therapist when she saw his neat and even stitching. One could almost always guess with accuracy that the patient reading with apparent absorption or concentrating on the writing of a letter was a recent admission to the ward. Conversation among the patients, as a rule, included the current athletic sport, their experiences on active service, or their ear, nose or throat ailments.

This morning they were unusually silent but most observant and alert. There was a new centre of interest on the ward. Finally, courage overcame mere curiosity. Addressing one of the three girls, who were making their beds and tidying their bedside lockers, one of the patients said: "That outfit you are wearing is a new one on me. Now just who and what are you?"

"I am Miss White," was the timid answer, "and we are the first class to take the nursing course now being given at this hospital. This is our first day on the wards and," gaining more confidence as she sensed the friendly interest of the patient, "I feel — sort of funny inside."

"Now, never you mind, Miss White, before you know it you'll be through

your training and become a head nurse or a top-shot of some kind."

"Oh, no Mr——? Jones? Mr. Jones — you have to be a graduate nurse to become a head nurse."

"But didn't you say you are taking a nursing course?"

"Yes," replied Miss White, "But we are training to be nursing assistants."

At this stage two of the other patients had drawn closer and the trainee, finding it difficult to cope with her audience and to concentrate on her work as well, released the tension she was applying to a drawsheet and devoted her attention entirely to the conversation. "We do not learn nearly all that a graduate nurse learns and our course is not as long either, but with our training we can help on the wards. We can do some of the treatments for some of the patients under the supervision of the registered nurse or, under the direction of the doctor, give nursing care to some patients in their homes."

It was on a morning in October, 1952 that the above conversation took place on one of our wards selected for preliminary ward experience for our trainees. The first class was enrolled in the Department of Veterans Affairs' School for Nursing Assistants at the Queen Mary Veterans Hospital in Montreal, in late September of that year. Two other such schools are located at the Sunnybrook Hospital, Toronto and at the Camp Hill Hospital, Halifax. The D.V.A. Schools for Nursing Assistants were organized by Miss A. J. Macleod, director of Nursing Services, D.V.A. and Miss Marjorie Russell, nursing consultant to the D.V.A. Each school has a full-time teaching staff of three graduate

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Miss Groenewald is director of the Montreal Central School for Nursing Assistants, Queen Mary Veterans Hospital, Montreal.



nurses with special preparation in teaching and supervision. Part-time instructors, who are specialists in their field, give instruction in the care of children and in elementary nutrition.

Our original teaching unit, here at the Queen Mary Veterans Hospital, was in a temporary building known as "Hut 10." With regret, almost, we must explain that the walls of our hut were not of clay, nor did it have a thatched roof.

On December 15, 1954 we moved into our spacious and elegant quarters in the new wing of the hospital. Reader, have you ever moved? If so, you will be smiling sympathetically. Not only do all those packing cases and boxes so carefully marked and labelled lose their distinguishing features en route but there seem to be twice as many of them when they are finally unloaded at their destination. While striving to appear cheerful and briskly competent in the midst of aforementioned unfamiliar packing cases, dismantled beds, unassembled bookshelves, etc., two snow-covered trees were dragged in! But of course, the school always has a gala Christmas party complete with a tree under

which are placed the gifts, brought in under "the-draw-a-name-buy a-seventy-five-cent-gift" system, which Santa Claus jovially gives out to the surprised recipients.

We are proud of our well equipped teaching unit consisting of a lecture room, library, demonstration room, diet laboratory, sitting room, locker room, and offices. Visitors assure us that our color scheme is most attractive. Against the backgrounds of various pastel shades the trainee in her distinctive short-sleeved yellow uniform, (with the D.V.A. insignia on the arm band) worn with a white bib and apron, organdy tie-back cap, and brown shoes and stocking makes a pleasing picture. Patients often refer to them as buttercups, daffodils or canaries.

Classes are enrolled twice a year. Trainees range in age from 18 to 40 and must have completed at least one year of high school. Creed, race, color or marital status does not bar an applicant though we emphasize the fact that home or other responsibilities must not interfere with attendance during the ten months of the course. Language difficulties? Yes, indeed —



*Qualified to Help.*

but in coping with these difficulties both instructor and trainee become quite resourceful. During the early weeks of the course one might have to demonstrate a hiccup to explain the meaning of the word. When one is informed that the coccyx is in the "downstairs region of the spine" one is definitely not disheartened!

The curriculum is based on the recommendation of the special committee of the Canadian Nurses' Association, and meets the requirements for certification in Ontario. Subjects taught in the school are elementary nursing, hygienic housekeeping, elementary biology, personal and community health and hygiene, elementary nutrition, adjustments and interpersonal relationships, care of mother and baby, care of children, first aid and bandaging, civil defence. In accordance with a resolution passed by the Committee on Educational Policy of the Canadian Nurses' Association, the basic course has recently been strengthened by emphasizing psychiatric aspects of nursing within the present outline.

The first four months of the course consist of theory, demonstration and practice in the classroom, and orientation to clinical areas and special departments in the hospital. As soon as a new procedure has been satisfactorily performed by the trainee in the demonstration room she is taken to a ward where she carries out this procedure under the supervision of an instructor from the school. Wards are selected and the trainees are given additional assignments as they progress. By the fourth month of their training they spend about three hours on the wards daily.

At the beginning of the fifth month the trainee starts her full-time ward experience. In addition to the Queen Mary Veterans Hospital the following hospitals participate in our training program: The Montreal General, Royal Victoria, St. Mary's, Queen Elizabeth and Jewish General. Each trainee spends four weeks at the Montreal Children's Hospital, two weeks in a nursery, two weeks on a maternity ward and approximately twelve weeks on medical and surgical wards in one of the above-mentioned hospitals. The trainee is under the supervision of a

member of the teaching staff of the hospital involved and of the head nurse of the ward to which she is assigned. An instructor from the school acts in the capacity of visiting clinical coordinator. Evening and/or night duty is limited to three weeks as supervision, individual and group clinical instruction and proper evaluation of trainees present problems, in most cases, during these hours of duty. Trainees are required to do "observation" studies on two or more patients during their term of full-time ward experience.

Directors of nursing in the participating hospitals act in an advisory capacity to the director of the school. Their interest and support is deeply appreciated and is most encouraging.

Graduation, which follows on the heels of final examinations, is for us the great day just as it is everywhere for anyone in any way involved with students. Sixty-two nursing assistants have successfully completed the course at the Queen Mary Veterans Hospital. With pride, though, we speak of 210 graduate nursing assistants. In April 1954, the Montreal School for Nursing Assistants, established in 1948 under the direction of Mrs. F. Fisher, amalgamated with our school and thus came into existence "The Montreal Central School for Nursing Assistants" as we are now officially known.

And after graduation? Excerpts from letters received from, and from conversations with, graduate nursing assistants tell their own story:

"This is a 20-bed hospital in a 500-peopled town. Most of the people are of Ukrainian origin and I have already learned seven words in that language. The work is rewarding and interesting. We have so many opportunities to do the things we were trained to do."

"When Mrs. S. goes to hospital I am going to look after Mr. S. and the two small children and I shall be staying on for one week longer when Mrs. S. comes home with the new baby."

"There are four graduate nurses and the three of us at this Camp for Crippled Children. Under the direction of the nurses we take care of the more severely handicapped children and also take part in the recreational activities of the camp. We are having an interesting and enjoyable summer."



"I am learning so much about the care of the patient with tuberculosis and have gone up the coast by plane on 'escort duty'."

"My patient's husband seemed so helpless and lost when I first came here. He is 74 and she is 70 — the cancer is quite advanced. I let him help me with the housekeeping duties and even with some of the nursing duties, and now he does not seem quite so sad."

In the home, in small hospitals, in outlying communities, and in our hospitals in the city, the trained nursing

assistant is taking her place on the nursing team and is proving her value. With a feeling of the worthiness of work well done in her own field, she shares in and relieves the professional nurse of some of the duties required of the nursing profession as a whole. In the words of Miss White "With our training we can help..." Under the direction of doctors and nurses they are helping to assure total nursing care of the patient and helping to maintain and promote the standards of the nursing profession.

## New Autoclave Tape

A Toronto nurse is credited with assisting greatly in the commercial development of a new autoclave tape that provides immediate identification of sterilized bundles and items in hospitals. The tape is employed for closing and sealing bundles prior to placing them in the autoclave or steam oven for sterilization. It is now in use in major Toronto and Montreal hospitals as well as in a number of hospitals across Canada.

A query by Phyllis Norton, supervisor of the Central Supply Room in the Toronto Hospital for Sick Children started months of research. She was looking for a new method of sealing wrapped items and a simple means of identifying them after processing. The product had to meet the qualifications of hospital sterilizing. The tape used had to withstand prolonged exposure to steam without losing its body and coming loose. It had to peel off readily without leaving a sticky residue. It had to adhere to all types of dry, clean surfaces such as linen, muslin, plastic, glass and metal. It had to have a backing that would take and hold markings through prolonged heat exposure.

After months of developing tapes that were passed on for testing, a product was devised which not only stood up under the steam and heat exposure, but adhered firmly long after processing. It could be stamped, written on with ink, pencil or crayon. The identification neither ran into the tape or material nor showed any sign of fading.

The problem of indicating whether or not



PHYLLIS NORTON

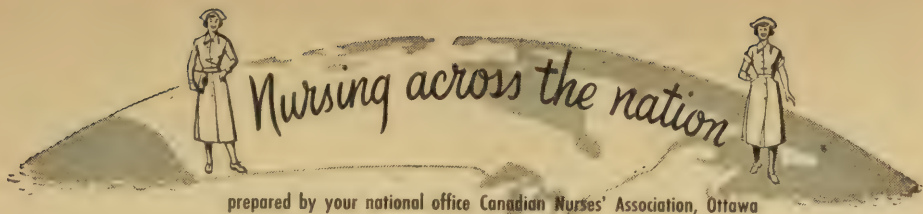
a bundle had been sterilized still remained. The final result is a marking that will become visible only after processing under the proper combination of heat and steam. Neither heat nor steam alone nor direct exposure to sunlight will register.

The autoclave tape is economical to use, because only short strips are needed to seal sizeable bundles. One 60-yard roll will seal approximately 720 bundles at an average sealing cost of six bundles for one cent. Because the packages are neater and more compact, they require less shelf space. A hazard of handling bundles is eliminated because there is less danger of accidental opening.

He listens to good purpose who takes notes.  
— DANTE

The most unhappy of all men is he who believes himself to be so.





## Nursing Education

SHOULD THE CNA BE GIVING more direction in regard to curriculum development? Are the various experimental programs under way in different parts of Canada really meeting the needs of nursing? These are some of the questions being asked by nursing educators. At its meeting in January, 1955, the CNA Committee on Nursing Education began a discussion on curriculum, but it was soon evident that constructive, far-sighted work could not be attempted until certain information was available. For, to advise on such matters, one must have a knowledge of the kind of worker which it is proposed will result from the educational program. Objectives must be clarified before curricula can be planned.

With this in mind, each provincial nursing education committee was asked to prepare a statement of its beliefs in regard to the "Philosophy, Aims and Objectives of the Basic Nursing Education Program." This was not an easy assignment. We think we know the goal towards which our teaching is directed, but when we attempt to put these thoughts into words they become very elusive.

The provincial committees have worked long and hard to prepare their statements. One province arranged a full day's conference for this purpose and produced a most comprehensive summary. Their approach was first to consider the general philosophy of curriculum development and, then, through small groups to consider the philosophy, aims and objectives of curriculum as it relates particularly to nursing education. Although at the time of writing, the CNA Nursing Education Committee has not studied the statements, it is possible to say that the theme which runs throughout them all is the importance of the

human element — to the student herself, to her patients, to the community, to her co-workers. We seem to be unanimous in realizing that, in order to meet her responsibilities, the nurse must have an opportunity for personal as well as professional growth.

## Ninth WHO Assembly

The Ninth World Health Assembly which will be held in 1956 has selected as the topic of the technical discussions "Nurses: Their Education and Their Role in Health Programs."

The International Council of Nurses and the International Committee of Catholic Nurses and Medico-Social Workers have been invited to attend these sessions as international non-governmental organizations in official relationship with the World Health Organization.

The I.C.N. has invited the affiliated national nurses' associations to promote discussion of the topic and to forward a summary of statement based on three broad questions:

- I. What is the present role of nurses in meeting the health needs of people?
- II. What do nurses see as their future role in (or contribution to) the total health program?
- III. What conditions, attitudes or educational facilities should be changed or developed so that nurses may successfully play the role envisaged?

It is our hope that the summary statement prepared by the CNA will appear within the pages of *The Canadian Nurse* at a later date.

## Pre-registration for 28th Biennial

Almost daily now pre-registrations are being received in National Office. Student forms are arriving minus names. The lucky girls who will be coming aren't named yet, but none-

theless everyone is entering into the spirit of the Convention. The registrants from Quebec seem to be in the majority. Remember, early registrants will naturally have a better choice of accommodation and the opportunity to choose the post-convention tour of their liking.

### *The Executive Meeting*

February is a busy month at your National Office. With its arrival come the numerous committee meetings which are a prelude to a Biennial Convention.

February 2, 3, and 4 find the Executive Committee meeting at the Chateau Laurier in Ottawa. Some 35 members of the Executive will be in attendance. These members are your elected representatives from all parts of Canada.

Here the reports of the five national committees will be presented and important developments discussed and voted upon. As an example, the Publicity and Public Relations Committee Report will ask the Executive to vote upon the recommendation that the Public Relations Guide prepared during this biennium be printed in both French and English. If this is agreed upon, the Guide will be ready for distribution during the Biennial Meeting in Winnipeg. This Guide is designed to give each nurse helpful suggestions in communicating with other professional personnel and with the public in general. The development of good chapter meetings is discussed within

its pages for it is here that the nurse develops her understanding of the profession and what it is trying to accomplish in terms of improved nursing service.

The Program Committee will have much to report as plans are finalized for the 28th Biennial Meeting. Details will be outlined concerning the various sessions, speakers announced and entertainment activities finalized by the Arrangements Committee which is composed of representatives from our hostess provinces, Manitoba and Saskatchewan.

### *Hospitalization*

Have any of you who are reading this been hospitalized lately? Have you been the patient instead of the nurse? We know of a nurse who recently became a patient for a few days. Amazed by the number of people who came popping in and out of her room, she began to keep count.

Within the first twenty hours of her stay in hospital no less than 14 representatives of the nursing team approached her bedside — the supervisor, seven registered nurses, three nursing assistants, three ward aides. Add to this the patient's doctor, two internes, a cleaning woman and a handy man who came in to do a few repairs, it was rather confusing even to a nurse, to say nothing of a person unfamiliar to hospital ways. Do you know that *not one of these members of the nursing personnel offered to introduce herself?* Better communications are definitely needed within our profession.

## *Le Nursing à travers le pays*

### *L'éducation en Nursing*

L'Association des Infirmières Canadiennes devrait-elle donner plus de directives concernant le programme d'étude? Les programmes actuellement à l'essai dans diverses parties du Canada répondent-ils vraiment aux besoins de la profession? Voilà des questions que se posent les éducatrices en nursing. Lors de la réunion de janvier 1955, les membres du Comité de l'Education en

Nursing amorcèrent une discussion sur le programme d'enseignement mais on se rendit bientôt compte qu'il était impossible de travailler d'une manière constructive et prévoyante à moins de posséder certains renseignements. Avant de pouvoir donner des conseils sur la préparation d'un programme d'enseignement, il faut savoir d'abord quelle formation l'on vise à donner et quels sont les objectifs à atteindre. Tenant compte de ce fait, l'on a prié chaque comité provincial



d'éducation en nursing de rédiger un exposé de la philosophie, des buts et objectifs du cours de base en nursing. La tâche assignée n'était pas facile. Nous croyons connaître le but vers lequel nous dirigeons notre enseignement mais lorsqu'il s'agit de concrétiser notre pensée par des mots, c'est bien moins simple.

Les comités provinciaux ont travaillé ferme et longuement à la préparation de cet exposé. Dans une province, l'on a organisé, à cet effet, une journée d'étude et on a présenté un résumé très au point. On a d'abord considéré la philosophie générale de l'élaboration d'un programme d'enseignement après quoi, des petits groupes se sont formés pour étudier la philosophie, les buts et objectifs d'un programme d'étude relativement à la formation de l'infirmière. Bien que le Comité national de l'Éducation en Nursing n'ait pas encore étudié tous les rapports présentés par les provinces, l'on peut déjà déduire que le facteur humain en est l'élément fondamental considéré par rapport à l'étudiante d'abord, puis à ses malades, à la société et aux personnes qui travaillent avec elles. Toutes semblent unanimes à réaliser que pour pouvoir assumer des responsabilités, l'infirmière devrait avoir autant l'occasion de développer sa personnalité que d'acquérir des connaissances professionnelles.

### *La 9ième Assemblée de l'OMS*

La neuvième assemblée de l'OMS, qui aura lieu en 1956, a choisi comme sujet de discussion: "Les infirmières, leur formation et leur rôle dans les programmes de santé."

Le Conseil International des Infirmières et le Comité catholique international des infirmières et des assistantes sociales ont été invités à cette réunion, à titre d'organisations officielles non-gouvernementales.

Le Conseil International des Infirmières a invité toutes les associations nationales à faire connaître leur point de vue en les priant de répondre à ces trois questions:

I. Quel est le rôle actuel des infirmières en ce qui concerne les besoins de la collectivité, en matière de santé?

II. Quelle sera la contribution des infirmières de l'avenir dans le programme sanitaire?

III. Quelles conditions, attitudes ou formes d'enseignement devront être modifiées ou développées pour permettre à l'infirmière de remplir avantageusement le rôle que l'on attend d'elle?

Nous espérons que le résumé préparé par

l'A.I.C. paraîtra prochainement dans l'Infirmière Canadienne.

### *Assemblée du Comité Exécutif de l'Association des Infirmières Canadiennes*

Février est un mois bien rempli au secrétariat national; dès les premiers jours, se tiendront les réunions des divers comités, en vue de la préparation du congrès biennal.

Les 2, 3 et 4 février aura lieu au Château Laurier, à Ottawa, l'assemblée du Comité Exécutif qui réunira 35 membres venant des diverses provinces et étant les représentantes que vous avez élues.

Les rapports que présenteront alors les cinq comités nationaux feront l'objet de discussions et les membres seront appelés à voter pour ou contre la recommandation qui sera faite par le Comité des Relations extérieures à savoir: que le guide préparé par ce comité soit publié en anglais et en français. Si cette recommandation est acceptée, le guide pourra être distribué lors du congrès de Winnipeg. Ce guide servira à apporter à l'infirmière des suggestions qui lui seront utiles dans ses relations avec les autres membres de la profession et le public. Un chapitre est consacré aux assemblées de districts car c'est là que l'infirmière apprend à connaître la profession et la valeur de ses services pour le plus grand bien de tous.

Le Comité du programme présentera un rapport intéressant sur l'organisation de la 28ième assemblée biennale. Des détails seront donnés sur les diverses séances, les conférences et les réunions sociales, par le comité d'organisation comprenant des représentantes des provinces hôtes, la Saskatchewan et le Manitoba.


### *Inscription préliminaire 28ième Congrès Biennal*

Presque tous les jours recevons-nous au secrétariat national des inscriptions pour le Congrès; les formules des étudiantes-infirmières ne portent pas de noms; celles qui auront la chance d'assister au congrès ne sont pas encore nommées; toutes ont l'espoir d'être choisies et ont déjà l'esprit du congrès. Les inscriptions reçues du Québec sont les plus nombreuses. Rappelez-vous que les premières inscrites auront un meilleur choix de logement et de participation aux voyages et excursions organisées après le congrès.

### *Hospitalisation*

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été hospitalisées, dernièrement? Vous est-il arrivé d'être la patiente au lieu de l'infirmière? Nous connaissons une infirmière qui a, récemment, été hospitalisée pendant quelques jours. Étonnée par le nombre de personnes qui entraient et sortaient de sa chambre, elle se mit à les compter. Durant les premières 24 heures, pas moins de 14 personnes du personnel hospitalier sont venues dans sa chambre — la surveillante, sept infirmières, trois auxiliaires et trois filles de salles. En plus, son médecin, deux internes, une femme de ménage et un ouvrier qui vint faire quelque réparation. Si c'était un peu embrouillant même pour une infirmière

que dire d'une personne qui n'est pas familière avec ce milieu? Savez-vous qu'aucune de ces personnes ne s'est présentée! Il n'y a pas à dire, nos relations professionnelles ont besoin d'être améliorées.

### *Chez les nôtres*

La rédactrice de l'*Infirmière Canadienne* et sa collaboratrice Mlle S. Giroux offrent à tous nos lecteurs leurs meilleurs voeux de Bonne et Heureuse Année. Elles remercient très sincèrement tous ceux et celles qui ont collaboré aux pages françaises de cette revue.

## Annual Meeting in New Brunswick

**T**HE MEMBERS OF THE New Brunswick Association of Registered Nurses were guests of the Moncton Chapter at their 39th annual meeting on October 19 and 20. The two-day meeting, held in the auditorium of the Hôtel-Dieu de l'Assomption, was attended by 165.

The first day's meeting opened with the president, Miss Grace Stevens, in the chair. The second day's meetings were chaired by the first vice-president, Miss Lois Smith. The highlight of the morning was the presentation of the first association life membership to Miss Alma F. Law, past secretary-registrar, who on her retirement had held office for 13 years. The citation was given by Miss Marion Myers.

In her presidential address, Miss Stevens spoke of the progress made in nursing education in New Brunswick through the appointment of Miss E. Kathleen Russell to study ways and means of organizing nursing education to give more adequate nursing service.

Following the report of the Committee on Finance, a motion that the annual active membership fee be increased from \$10.00 to \$12.00 was passed unanimously. The Nursing Service Committee presented some changes in Recommended Personnel Policies which were accepted.

The educational program of the meeting centred on public relations and following the report of the Committee on Publicity and Public Relations, a rôle-playing presentation of various situations met with in hospitals was given under the direction of Miss H. Jean Lynds.

We were fortunate in having as our guest from National Office, Miss Rita MacIsaac who spoke on internal communications. Her

topic "It's Up to Us" served to round out the program on public relations and gave a wealth of information on the relationship of the individual nurse to her provincial, national and international nursing organizations, with guidance for successful public relations.

The report of the Committee on Nursing Education noted that some projects which need to be studied will remain pending until the results of the nursing survey are made public in the fall of 1956. A recommendation that the New Brunswick Association of Registered Nurses set aside the sum of \$2,000 for the purpose of student loans was accepted.

Miss E. Kathleen Russell was introduced to the members and spoke of the research being conducted as a cooperative effort. She said that there was need for a firmer recognition of the depth and breadth of nursing services demanded today; that the aim of the research was to find recommendations in order to produce more nursing service, more adequate nursing service, and nursing service to meet all the demands of nursing.

The Committee on Legislation and By-Laws recommended that legislation for the auxiliary nurse be delayed until after the research project on nursing education is completed. Provincial office was authorized to charge \$1.00 for an endorsement and \$2.00 for a complete transcript in completing registration credentials.

Other committee reports of provincial interest were given. Reports from the eight chapters showed a range of activities and interests, with many vital topics and active participation in educational programs by the members themselves.



## "Meat....may be fed at any age"

**J**EAN AND MARRIOTT's statement in 1947 in their book "Infant Nutrition" that "Meat appropriately prepared may be fed at any age" has been reinterpreted many times since in the light of clinical evidence.

Liverton & Clark (J.A.M.A. 134,1215 (1947) show that infants of six weeks readily accept and benefit in terms of hemoglobin concentration and erythrocyte count, from a formula which increases their protein intake by 25% by the addition of Swift's Meats for Babies.

*Swift's Meats for Babies are prepared from fine lean meats, specially pre-cooked to retain their high nutritional values, and strained to a custard-like consistency. There are seven varieties, beef, veal, heart, liver, liver and bacon, pork and lamb. Swift also prepares Egg Yolks for Babies, Salmon Seafood for Babies, and Chopped Meats for Juniors.*

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At the annual dinner held at the Brunswick Hotel, John Fisher was guest speaker and delighted his audience with his wit and general Canadiana philosophy.

Prominence was given to the coming CNA biennial at Winnipeg through the showing of a film, and a pep talk by Miss MacIsaac.

The officers of the Association remain unchanged, and are: President, Miss Grace Stevens; first vice-president, Miss Lois Smith; second vice-president, Mother Bujold; honorary secretary, Sister MacKenzie.

MURIEL ARCHIBALD  
*Secretary-Registrar*

## Sélection

### *L'enfant à l'hôpital*

Observons l'enfant à l'hôpital, dans cet entourage étrange pour lui, calme, propre, blanc, tout en ordre; dans cette ambiance tellement opposée à son caractère d'enfant, lui qui a besoin de mouvement, de vie, de bruit, d'un peu et parfois de beaucoup de désordre. Il subira des traitements divers, piqûres, lavements, soins de plaies opératoires, sans parler de l'intervention elle-même. Il risquera d'être seul pendant de longues heures. Il aura mal parfois, et personne ne sera près de lui pour l'aider à mieux supporter ce mal. Oui, assurément, l'hospitalisation est une épreuve réelle pour l'enfant. Et surtout pour le petit de moins de 5 ans, alors que souvent, malgré les explications fournies, il ne réalise pas pourquoi on l'a abandonné en ce lieu inconnu et apparemment hostile.

Il en est ainsi surtout pour la raison suivante: l'enfant — et surtout le petit d'âge préscolaire — vit essentiellement dans le présent. Il est incapable d'anticiper et d'envisager ce séjour en clinique comme un événement passager. Et son désespoir en est d'autant plus grand. Ainsi, lorsque sa mère l'a quitté, pour lui, c'est comme si elle n'existait plus. L'enfant de 6 ans et plus acquiert progressivement la notion du futur; l'épreuve lui en est facilitée. Il sait qu'il rentrera chez lui. Toutefois, pour les grands enfants aussi, l'épreuve est réelle et il faut les aider à la supporter.

L'intervention, si elle a lieu, est évidemment le point crucial du séjour à la clinique. Il est souhaitable que les parents restent près de l'enfant avant et après l'opération. Il se sentira ainsi un peu plus en sécurité. Cette journée-là est pour l'enfant, comme pour les parents, une épreuve. L'enfant a

besoin de la présence d'un de ses parents, de sa simple présence. Il ne demande pas à jouer. Il ne demande pas de bruit. Mais il n'aime pas être seul. La proximité d'un être familier — calme et qui le réconforte — lui est une aide considérable.

### LES VISITES

Faut-il rendre visite à l'enfant? Non, nous a dit une mère de famille, "cela ne sert à rien et ça l'énerve. Quand nous ne sommes pas là, il est calme, et dès que nous arrivons, ce sont des hurlements..." En fait, la mère disait cela parce que les hurlements en question l'indisposaient très fort, et qu'elle ne réfléchissait pas au vrai motif de ces pleurs. "Non" vous diront également certaines infirmières, en employant les mêmes arguments. "Dès que les parents arrivent, ma salle d'habitude calme, s'emplit de pleurs et de cris. C'est affreux!"

Eh! oui, c'est affreux... Souvent les enfants pleurent! Mais pourquoi? Ils pleurent pour se libérer de toute l'angoisse accumulée pendant les heures de solitude. Et s'ils demandent encore et toujours à leurs parents de les emmener, c'est parce qu'ils n'aiment pas vivre dans cette salle d'hôpital. Il semble certain, au contraire, qu'il faut rendre visite à l'enfant hospitalisé, et aussi souvent que possible. Que faire s'il pleure? Il faut laisser passer le flot de larmes, et quand l'enfant se calme peu à peu, jouer avec lui, lui donner un petit cadeau qui lui dira que l'on a pensé à lui, même en son absence. Que les parents lui parlent de la maison, de l'école, qu'ils lui disent qu'on pense à lui, qu'on sera heureux de le retrouver au foyer... Ainsi l'enfant sentira que les liens avec sa vie habituelle ne sont pas rompus, qu'on l'aime et qu'on ne l'oublie pas.

Il faudra évidemment observer les règlements en vigueur à la clinique. Si les visites

Extrait de la revue *L'Enfant* éditée  
par L'Oeuvre Nationale de l'Enfance de  
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sont autorisées pendant toute la journée, il est possible d'organiser des visites répétées par différents membres, bien choisis, de la famille: parents, grands-parents, frères et soeurs... Il est très important de ne pas tromper l'enfant quant à la fréquence des visites, de ne pas le faire attendre en vain. Son sentiment de sécurité serait encore ébranlé. Quelle est la durée optimum des visites à un enfant malade? Eh! bien, ici cela dépend de nombreux facteurs: âge de

l'enfant, personnalité des parents, gravité de l'affection, occupations ménagères ou autres, de la mère... Il semble cependant que la présence de sa mère ou de quelqu'un de bien connu soit pour l'enfant un élément favorable.

N.B. Nous regrettons ne pouvoir citer que ces quelques lignes de cet intéressant article écrit par le Docteur E. Alfred Sand de l'Université de Bruxelles.

## Portrait Unveiled

At a ceremony on November 15, 1955, a posthumous portrait of Miss Mary S.



*Posthumous portrait of Mary S. Mathewson, B.Sc., by Robin Watt, M.C., A.R.C.A., unveiled in Livingston Hall, The Montreal General Hospital.*

Mathewson, assistant director, School for Graduate Nurses, McGill University, 1936-46 and director of nursing of The Montreal General Hospital, 1946-53, was unveiled by Miss Norena S. Mackenzie, president of the Alumnae Association of the School of Nursing. Miss Mackenzie, who was a close friend and professional associate of Miss Mathewson, paid tribute to the unique qualities which resulted in her outstanding contribution to the fields of nursing education and public health.

Miss Ann Peverley, who acted as chairman, stated that the portrait was undertaken in response to requests from friends and colleagues in many parts of the world, and has been made possible by their contributions. Mr. W. S. M. MacTier, president of the hospital, in accepting the portrait, expressed his appreciation on behalf of the Board of Management.

At a reception following the unveiling ceremony, the coffee table was presided over by Miss Rae Chittick, director, School for Graduate Nurses, McGill University, and Miss Mary Ritchie, Assistant Chief Nurse Department of Health, City of Montreal.

## New Spectacles Aid the Deaf

Spectacles with built-in hearing aids have been developed as the result of recent advances in the making of miniature electronic components. The battery for the new aid is the size of a dime. Known as the "Spectaphone," the new hearing aid uses a transistor. It marks 30 years progress in the search for an efficient and unobtrusive hearing aid. To solve the problem of coordinating the production of the aid with the older

craft of spectacle-making and fitting, selected agents will carry stocks of partially completed frames in a range of sizes, and assemble them when the eye prescription is filled. Many styles will be available to suit wearers in different regions, and the range will be adjusted to meet average sizes and shapes of heads. The Spectaphone is manufactured by Fortiphone Ltd., 247 Regent Street, London, W.1., England.



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# Book Reviews

**Textbook of Physiology**, by Caroline E. Stackpole, A.M., and Lutie Clemson Leavell, M.S. 418 pages. The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1953. Price \$5.00.

*Reviewed by Irene Feely, Science Instructor, General Hospital, Brantford, Ont.*

This book has evolved from the authors' appreciation of "certain fundamental problems that confront students of physiology, regardless of their primary interests."

The eight problems, which provide the titles for the sections that comprise the book, are: 1. Maintaining a balance between rest and exercise, work and play. 2. Maintaining an awareness to the environment. 3. Maintaining circulation. 4. Maintaining a constant oxygen supply. 5. Maintaining the protective mechanisms of the body. 6. Maintaining the nutrition of the body. 7. Maintaining the fluid and electrolyte balance of the body. 8. Perpetuating the human race. These sections are subdivided into convenient lengths for teaching purposes.

The information is laid down in a direct manner. It is aided frequently by comprehensive tables as well as diagrams, some of which should encourage students to develop this useful way of retaining or expressing knowledge. The terms used are familiar to students using anatomy and physiology texts of which these writers were co-authors.

Consciousness of the "problem-solving approach" was noted in the preface, and in the questions following some chapters. The customary introduction of "examples" lends reality to the subject. To appreciate this book of physiology the student nurse needs a basic core of anatomy. There is sufficient anatomy provided for recall to make it an interesting and worthwhile study or reference source for nurses, and, in topics of general interest, to orient a reader with a particular interest.

**A Manual of Psychiatry**, by K. R. Stallworth, M.B., Ch.B. 314 pages. N. M. Peryer Ltd., Christchurch, New Zealand. 2nd Ed. 1953.

*Reviewed by Miss Pearl Graham, Superintendent of Nurses, Ontario Hospital, New Toronto, Ont.*

This manual has three definite objectives: (1) To provide valuable information for the general practitioner regarding psychiat-

ric patients; (2) as a guide to students of psychiatry; (3) to disprove the belief that psychiatry is a specialty rather than a necessary part of medicine. All objectives are accomplished fairly well. Since technical terminology is at a minimum, the book is of value to laymen also.

It is divided into 28 chapters. Eight of the earlier chapters deal with etiology, routines, classifications and mental hygiene. Chapters 9-16 cover types of illnesses, neuroses, deficiency, epilepsy, psychopaths and psychosomatic medicine. The last three chapters deal with treatment and nursing measures. Definitions are simple but excellent. "Intelligence is the ability to profit by experience, to grasp essential meanings of past experience and apply them to the future."

The author stresses the fact of "contagion" in dealing with heredity and environment. The chapter on mental hygiene has valuable suggestions for the preventive side of psychiatry. Treatment data is clear although methods vary in different centres. However, the explanations given will allay the fears of the general public.

This text would be a worthwhile addition to a nursing library, particularly as an introduction to psychiatry. More detail would seem desirable for those who wish advanced study.

**Smoking and Cancer, a Doctor's Report**, by Alton Ochsner, M.D. 86 pages. The Copp Clark Co. Ltd., Toronto. 1954. Price \$2.25.

*Reviewed by Margaret Nesbitt, Cancer Clinic, Victoria General Hospital, Halifax, N.S.*

Dr. Ochsner is well qualified for the task of pointing out the hazards of smoking, which he has undertaken in this book. By the use of ample references to authoritative research studies and his own findings, he leaves little doubt of these dangers.

Smokers in particular should read this simple, straightforward account of what happens in their systems in relation to their nicotine intake. The statement that "heavy cigarette smoking more than doubles the death rate from cancer and nearly doubles the death rate from coronary disease" should not be taken lightly.

Dr. Ochsner digresses from the problem of "Smoking and Cancer" enough to show

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other serious conditions that threaten the smoker in much greater proportion than the non-smokers. He also criticizes the tobacco companies for their advertising methods and their lack of responsibility for the health of their customers.

The author, realizing that the use of tobacco will continue with the years, has given a suggested program for breaking the habit. For those who will not give it up completely he outlines the methods by which the health risks may be minimized.

**Physiology and Anatomy** by Esther M. Greisheimer, Ph.D., M.D. 808 pages. J. B. Lippincott Company, 2083 Guy Street, Montreal. 7th. ed. 1955. Price \$5.00.

Previous editions of this text are well-known to instructors and students of nursing. The present edition has undergone re-evaluation of content and certain changes in manner of presentation. The author's objective was to increase the value of the text as an aid in teaching and learning.

The book is divided into five main units. The various systems of the body are allocated and discussed under the appropriate headings. Each chapter contains a very concise summary of its contents. Study questions of the multiple choice variety are included at the end of each chapter as well. These are interesting and valuable but in some instances seem too advanced for the preclinical student. A new section — "Practical Considerations" — has been introduced. This developed as the result of questions asked by students. It constitutes a brief discussion of some of the common pathologic conditions associated with specific body systems. For examples, arteriosclerosis, aneurysm, and varicose veins are dealt with under the anatomy and physiology of the circulatory system. There are a large number of illustrations — a considerable proportion of them in color. They are clearly labelled and understandable. A glossary has been prepared to aid in familiarizing the reader with anatomical and medical terminology.

One section deserves special mention. Most students find the study of the nervous system difficult. This may be the result of the tendency to separate the system into its component parts instead of regarding it as an integrated unit. The author has approached the subject with the emphasis on integration. The use of a familiar situation — an aching tooth — as an analogy

in the introductory remarks attracts one's attention immediately. The section is well illustrated with tables and diagrams. The discussion is detailed but pertinent. There has been greater emphasis placed upon relating the rôle of the nervous system to familiar bodily activities.

This is a very readable and useful book. The instructor in anatomy and physiology should find it a valuable aid. Some may consider that there is too much detail. The author anticipated this but included additional information for the student who might be lacking in a supporting basis of scientific knowledge. Considerable thought has been given to the sequence of subject matter based on the needs of the student nurse. For the less experienced instructor, the use of the text *Teaching Physiology and Anatomy in Nursing* by H. H. Flitter and H. R. Rowe in conjunction with this book would be very helpful.

**Teaching Physiology and Anatomy in Nursing** by Hessel H. Flitter, R.N., B.S., M.A., and Harold R. Rowe, R.N., B.S., M.S. 56 pages. J. B. Lippincott Company, 2083 Guy Street, Montreal. 1955. Price \$2.00.

The new instructor often has difficulty in deciding upon the best method to use in presenting her subject. In the words of the authors "this book is intended to offer help to the beginning instructor in physiology and anatomy." To make the text more meaningful, it was developed with specific reference to *Physiology and Anatomy*, 7th edition, by Esther M. Greisheimer.

In introduction there is a general discussion and definition of the usual approaches to teaching. Such terms as "correlation," "integration," and "content-centered approach" are clarified. Succeeding units are related to corresponding units of Dr. Greisheimer's book. No attempt is made to organize subject material for teaching purposes. Suggestions and ideas are offered for the use of the instructor in choosing the best method of presentation. The importance of teaching this subject in integration with the rest of the curriculum is emphasized. Using the student's past experiences as a basis for imparting new information is also stressed.

A plan of time distribution of content is given. This is of limited value. The number of hours allotted to each subject varies from one school to another depending on the organization of the curriculum. A course

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outline is included in conclusion. Senior instructors may have mixed feelings in regard to this. The new instructor will undoubtedly be grateful for it.

It would appear that the authors have accomplished their purpose. While designed primarily for the less experienced instructor, the senior instructor may conceivably find a fresh approach to a familiar subject. This text should prove very useful.

**Supervision of Nursing Service Personnel**, by Cecilia M. Perrodin, R.N., M.S.N. Ed. 622 pages. The Macmillan Company of Canada, 70 Bond Street, Toronto 2, Ont. 1954. Price \$6.00.

*Reviewed by Miss Jeanie S. Clark, Director of Nursing, University Hospital, Edmonton, Alta.*

The author of this textbook was formerly assistant professor, Nursing Education, De Paul University, Chicago, Illinois. In the preface, she states her three purposes in writing this book as follows:

1. In an effort to demonstrate the role of the nursing supervisor as a harmonizer and a key figure in the achievement of a desirable balance between the legitimate aspirations of those directly or indirectly affected by supervision: patients, community,

nursing personnel and hospital and nursing administration.

2. From a belief "that this is the age of supervision, that supervision is the answer to many of the problems of nursing service in all hospitals, large and small, and that a guide to supervision will be welcomed by administrator, supervisors, and teachers."

3. To satisfy students, who, when pursuing courses in nursing education frequently and legitimately complain that they receive the same content in nursing administration courses that they receive in nursing supervision.

It would appear that Miss Perrodin writes on the subject of supervision of personnel assuredly. She has had extensive experience and contacts in the nursing service field and also contacts in the fields of industry and business. She handled her subject under eight units:

Unit One: The Nature and Meaning of Supervision.

Unit Two: Basic Concepts of Importance in Supervision.

Unit Three: Principles of Supervision and their Relation to Supervisory Practices.

Unit Four: Analysis and Organization of Supervisory Activities, Requirements and Qualifications.

Unit Five: Tools of Supervision.

Unit Six: Contributions of Education, Business and Industry to Supervision.

Unit Seven: The Supervisory Program.

Unit Eight: The Fruits of Supervision.

At the end of each unit there appears an extensive bibliography for the use of readers who wish to pursue further references on the subject.

The material is well organized and set out frequently in a tabular or illustrative way. There is a discriminating use of a large and small type which aids in rapid comprehension. For the student and for the nursing service supervisor, this textbook should fill a very real need. I feel that the author has successfully achieved her three purposes.

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- (5) Box 292, North Bay, Ontario;
- (6) 55 "B" St. Joseph Street, Quebec, P.Q.;
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Chief, Personnel Division,  
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— NEWS OF RED CROSS

\* \* \*

The maiden who takes her time about marrying is usually happier than the one who enters matrimony early in life. This is a conclusion drawn by sociologists from a study of 604 young women, single and married. Psychological tests indicate that the single girls "had better emotional adjustment, greater self-reliance and a greater sense of personal freedom." The tests also

showed that those who are in no hurry to marry are less likely to be anti-social. Although most authorities on marriage agree that a woman should not marry until she is emotionally mature, one sociologist points out that their advice is not always followed because it is the immature and emotionally insecure young woman for whom marriage has the strongest appeal. — (ISPS)

\* \* \*

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The 1956 Spring Examinations for Provincial Registration will cover two groups of candidates, and will be held as follows:

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Graduates desiring to qualify for a license to practise will write on *April 9th, 10th and 11th, 1956*. Candidates will not be permitted to write these examinations until they have actually completed their training and hold the diploma of their school.

*Applications must be received by February 29th, 1956.*

### Examinations for Registration — Part I:

Students who will have completed their first year will enter the Examinations for Registration, Part 1, which will be held on *March 19th, 20th, 21st, and 22nd, 1956*.

(Time to be announced in each school.)

*Applications must be received by February 8th, 1956.*

For application forms and all information relating to the examinations, apply to the headquarters of the Association.

A. WINONAH LINDSAY, R.N.,  
Secretary-Registrar.

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— SIR FARQUHAR BUZZARD

## News Notes

### ALBERTA

#### DISTRICT 1

##### PEACE RIVER

The officers for the coming year were elected at the last meeting of the season: J. Wickett, president; Mrs. Wanda Campbell, vice-pres.; Mrs. E. Holmes, sec. treas.; committee conveners: Advertising, Mrs. MaMrguerite Greenfield; welfare, Mrs. Nancy Sproul; entertainment, Mrs. Alice Flinn.

#### DISTRICT 2

##### CAMROSE

The annual Nightingale Dance was held in November under the auspices of the chapter. It was suggested at one of the regular monthly meetings that the members might assist in furnishing the new Community Rest Room as a worthwhile project. At a later meeting it was decided to purchase a play-pen and a bottle warmer to be donated in the name of the chapter to the new community centre.

##### WETASKIWIN

Mrs. Bresden was appointed as a corresponding member of the Institutional Nursing Committee. The delegates to the annual convention, 1955, have been appointed as a committee to study and submit any necessary recommendations in regard to plans for the 1956 meeting.

At the November meeting of the chapter, Mrs. Asp and Mrs. Climic were appointed to select a slate of officers for 1956. It was decided to donate a sum of money to the Bethany Home to help in the work with orphans and children from broken homes. The guest speaker, Rachael Tasker, gave a very interesting talk on "Home Delivery." The January meeting featured a special program under the direction of Mrs. McWhinnie. High school girls interested in nursing, were guests of honor on this oc-

casion. It is hoped the opportunity to associate with active nurses and to discuss student nurse life will encourage future candidates.

Other guest speakers during the season have been Elsie Henschell, Sydney, Australia and Mr. Schumacher both of whom showed slides of their visits to many parts of the world.

### DISTRICT 3

#### CALGARY

The members of this chapter have had a very busy term. I. Stewart attended a session of the local branch of the Canadian Mental Health Association. Her report proved extremely interesting. The major projects for the past year of the Council of Social Agencies were outlined for the members by Miss D. Guild at one of the meetings. Miss Algard attended a session held by the Women's Bureau, Department of Labor, at which Miss M. Royce, director of the bureau, was guest speaker. Her report clarified the functions of this department. Earlier this past year Sister Leclerc attended a convention for Catholic hospitals and schools of nursing in St. Louis. Members were interested in the highlights which she later presented to them.

A motion to hold a minimum of four chapter meetings a year has been approved. This will require amendment of the district by-laws. At a supper meeting late in the fall, the following officers were elected for the coming term: A. Fallis, president; Mrs. M. Duthie, vice-pres.; J. Cummings, secretary; Mrs. N. Milan, treasurer. In her greeting Miss Fallis expressed the hope that each one would take an active part in the association and thus assure the success of its work.

Interested members were invited to attend a meeting of the Institutional Nursing Committee and to spend an evening at the Calgary Associate Clinic. The need to study the proposed revision of by-laws was emphasized.

The best wishes of the chapter were extended to F. Ferguson for success and happiness in her new endeavor in Ceylon.

#### HIGH RIVER

Chapter meetings have been well attended, and programs have been interesting. Dr. Little, a recent speaker based his lecture on the subject of "Rest" and the ill effects of confinement to bed. Dr. M. Rowland spoke on the prevention of communicable diseases through immunization, and used a film "The Body Fights Bacteria" to emphasize his remarks at the November meeting. A membership committee has been formed under the direction of Mrs. Robertson and J. Hagg.

Mmes. MacDonald, Betton, McRae and Lyon took charge of the January program. The slate of officers elected for the year was: Mrs. Irving, president; Mrs. White, vice-president; Mrs. J. Dougherty, secretary and R. Sarson, treasurer.

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## OLDS

Several members assisted in "Operation Lifesaver" by setting up a first aid station for that day. Mrs. Kinder has been chosen corresponding member to the Institutional Nursing Committee.

## VULCAN

Provision of a T.V. set for a shut-in and development of a plan of assistance for a rheumatic heart sufferer have been among the projects undertaken by members of this chapter. Home nursing lectures have been tentatively planned for the future. Mrs. S. Christianson was appointed secretary for the Civil Defence home nursing course.

## DISTRICT 4

### MEDICINE HAT

Fall and winter activities were resumed at a meeting of the members early in September. The private ward at the Maternity Hospital, which was furnished by the district, is to be provided with new curtains. Mrs. Anderson and Mrs. Montgomerie placed a wreath at the Cenotaph.

Proposed revisions of the by-laws have been studied by a committee under the direction of Miss Bietsch and a report forwarded by this chapter of the A.A.R.N. The Community Nursing Registry report showed considerable activity for November. It was decided that the constitution and by-

laws of the registry should be printed in booklet form. Mrs. Renner gave a comprehensive report of the work of the institutional nursing committee at a recent chapter meeting. A brief resume of the civil defence course which she attended in Arnprior was given by Mrs. McKay. The annual meeting was held in January at which the slate of officers for 1956 was presented.

## PROVOST

The possibility of sponsoring a blood donor clinic as a chapter project is to be explored. It was recommended that a representative of the local Red Cross branch be invited as guest speaker for a future program.

The development and care of children's teeth was the subject of a discussion by Dr. H. Canniff at a recent meeting. The members found the information educational as well as very interesting.

## DISTRICT 5

### HANNA

New officers elected for the term are: Mrs. I. Pelletier, president; Mrs. E. White, vice-pres., and M. MacKinnon, secretary. Mrs. B. Stephens and M. Fredgin are in charge of program planning.

Civil defence was discussed by Dr. Argue at one of the earlier chapter meetings.



## DISTRICT 6

### LACOMBE

Twenty-two members were present at the first meeting initiating the fall and winter program. The chapter plans to assume responsibility for the drive for funds for the Cancer Society — a project successfully undertaken in 1955. A buffet supper in connection with the nurses' formal dance was served as a means of raising funds for the treasury. Dr. McKibbin provided the members with the latest information on the toxemias of pregnancy following the business session.

A detailed and interesting lecture on nephritis by Dr. McFetridge was thoroughly enjoyed by the audience at a later meeting. It was planned to invite a representative of the Cancer Society as a guest speaker at a future meeting.

### RED DEER

The past year has been both active and interesting. A bylaw committee was formed to study revisions and then submit them to the executive and members of the provincial association for approval. Funds were provided to help pay treatment expenses for a worthy patient and a donation was made to the polio drive. It was also decided that a contribution should be made to a charity fund. Miss Yuill and Mrs. McKeoun attended the annual provincial convention earlier this year.

Increasing the active membership has received serious consideration. Members have been asked to cooperate individually in trying to increase attendance. Dr. More, Mrs. C. Van Dusen and Mr. Taylor, psychologist, have been guest speakers at various times during the past year. Miss Ross from the V.O.N. headquarters, Ottawa, was present at one meeting and outlined the steps necessary to set up such a service in the district.

The establishment of a nursing scholarship has been undertaken as a major project by this chapter. A committee has been formed to draw up the list of requirements necessary. It has been decided to use a portion of the funds to assist a student to complete her basic nursing education. Mrs. Davis was nominated to represent the institutional nursing group. Members enjoyed a social evening at their December meeting.

## DISTRICT 7

### JASPER

Miss Gilda Graves, whose work among the Indians with her study of rare blood types has provided so much interest, gave a very informative address at a recent meeting. Dr. Venner discussed "Misunderstood Illnesses of Childhood" and "Epilepsy" as guest speaker during the past year. It was decided to seek advice in the selection of films which would be of interest to the members.

The topic of breast cancer was discussed



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by Dr. Betkowski and a film shown at a late fall gathering. Plans were completed for the monthly Baby Clinic and three members were selected to assist with this. The Christmas banquet was held in the C.N.R. dining room and was followed by a party at the home of Mrs. Graves. Dr. O. Hogan, Dr. and Mrs. Betkowski and Dr. Vinner were honored guests for the evening.

#### EDMONTON

Discussion of proposed by-law changes was of major concern at a recent chapter meeting. A suggestion that an enlarged executive of the district meet and study such changes was accepted. R. McLure gave a most interesting talk about her course in public health which she had taken in Pittsburgh. Many highlights about the city itself were included. Miss McLure acted as chairman of the nominating committee for the January meeting.

#### STONY PLAIN

The programs for future meetings have

been the chief topics of discussion at chapter sessions this past fall. Members have been submitting suggestions in regard to this. Welfare organizations are to be approached with the hope of obtaining speakers. A recent guest speaker was Dr. Gillespie, medical health officer for Lac St. Anne Health Unit. His topic, "Maternal Deprivation and Mental Health in Children" was most interesting. Two films, "Crossroads" and "Miracle Fluid" were presented at one of the past meetings and proved both educational and enjoyable.

#### VERMILION

The following slate of officers was elected for the current season: Mrs. K. Brix, president; Mrs. Alice Soldan, vice-pres.; Mrs. V. Barr, secretary; J. McPhee, treas.

The chapter is directing a scrapbook competition on Cancer Education among school pupils in the local area. This contest is being sponsored by the Alberta division of the Canadian Cancer Society. A home cooking sale was held late in the fall as a money making project.

## DISTRICT 8

### PINCHER CREEK

Members of the chapter assisted with the Blood Donor clinic held recently. A course in home nursing has been planned with two volunteers from the chapter contributing their services.

### TABER

An organizational meeting was held in the Municipal Hospital to form a chapter of the A.A.R.N. The officers elected were: Mrs. Nicol, chairman; Miss Gamble, vice-chairman; Miss I. Okamoto, secretary; Mrs. Rash, treasurer. Bylaws were adjusted and accepted. Meetings are to be held monthly. Members have decided to help with the Baby Clinic as one project and to sponsor the annual nurses' dance.

## BRITISH COLUMBIA

### LADYSMITH

The annual meeting of the chapter was held in November with 15 members present. Mrs. J. Berto presented the report of a successful year with varied activities.

Officers for 1956 were elected as follows: President, Mrs. H. Steele; vice-pres., Mrs. P. Gannon; secretary, Mrs. J. Ulaga; treasurer, Mrs. J. Mitchell; social convener, Mrs. A. Quayle. Miss O. Jami, Miss H. Fulmore and Mrs. D. B. Quayle attended the institute in Nanaimo on "Body Mechanics and Rehabilitation Nursing." Miss C. Charters conducted this valuable course which was sponsored by the R.N.A.B.C. The purpose of the course was to provide instructors for the local chapters.

### VANCOUVER

#### *St. Paul's Hospital*

The members of this year's graduating class were entertained at a buffet supper by the alumnae association. Mrs. Collishaw presented a trophy to the outstanding student in each section on behalf of all alumnae members. Outside graduates presently on staff were guests of honor at the annual Christmas party. A bazaar was held early in December and featured home cooking and sewing.

News of the graduates reveals that A. Klassen, N. Martens and A. Friesen are working in Kelowna. A. (Mellor) Pulfer is on the staff of the Royal Inland Hospital, Kamloops while B. J. Mellor is at the King Edward VII Memorial Hospital, Bermuda. R. Wolfe is working at the Western Hospital, Toronto and Miss Galloway at Welland County Hospital, Ontario. P. Johncox completed her postgraduate studies in surgery at the General Hospital, Vancouver and is in Fresno, Calif. E. Ropas and P. Branca have started postgraduate study in surgery in their home school. G. (Larson) Alder has joined the staff of the Central Supply Dept.

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## NEW BRUNSWICK

MONCTON

*General Hospital*

*Nurses' Hospital Aid*

Authority to purchase a motion picture screen for the nurses' classroom was given to K. Richardson and Mrs. C. Colwell. This was an outstanding feature of the November meeting of the members. A recent cooking sale with a drawing for a cake added substantially to treasury funds. Small gifts were collected for distribution to sick members at Christmas. Mrs. C. Forsythe was welcomed as a new member. The student nurses were presented with 25 season skating tickets as a Christmas gift and the members enjoyed a special Christmas program and exchange of gifts at their December meeting.

## ONTARIO

DISTRICT 5

TORONTO

*St. Michael's Hospital*

A meeting of the alumnae association was held prior to the Christmas season. Plans were made for the preparation and mailing of gift boxes to sick nurses, and for a theatre night. The annual nurses' dinner was held early in December in the residence.

G. Ferguson has been appointed to the teaching staff of the obstetrical department. M. Hough has joined the staff of Baker Clinic, Edmonton. M. Willsher is stationed in Zweibruchen, Germany with the R.C.A.F., while M. MacKenzie is working in St. Joseph's Hospital, Ann Arbor. S. Walker is presently in New York at the Neurological Institute, Presbyterian Hospital. B. Burns is taking postgraduate study at Boston University. R. Krmpotic has joined the staff of Franklin Hospital, San Francisco. B. Kelly and M. Noble are on the staff of the Montreal General Hospital. The appointment of F. Roach as Dean of Nursing Education, Assumption College, was noted with pride.

*Women's College Hospital*

In recognition of her years of service and as a token of their regard for her, members of the alumnae association presented Miss C. Dixon with a piece of luggage. The presentation was made by Mrs. Mary Roberts. Mrs. M. Hood, who also has given many years of faithful service to her hospital and alumnae, received a life membership in the association and a bouquet of red roses. These were highlights of the last meeting of the association for 1955 at which Dr. Ferreira was the guest speaker.

The class of 1931 is making tentative plans for a reunion, marking their 25th anniversary, following the graduation dinner this coming spring. It is hoped that other

classes will follow their example. H. Muir has joined the staff of the new Sudbury Memorial Hospital. R. Duff visited the hospital recently and was the guest of honor at a buffet supper and a tea. M. Kerr recently returned from Europe.

## DISTRICT 12

### KAPUSKASING

A new chapter has been formed which includes Cochrane, Kapuskasing and Hearst areas. In spite of the distances which must be covered to permit attendance, interest is high and the members plan to hold monthly meetings — eight in Kapuskasing and two in Cochrane. The first meeting was held in November at the Sensenbrenner Hospital under the chairmanship of Mrs. Loosemore, district president. The slate of officers elected was: G. Larocque, president; J. Warrington, 1st vice-pres.; Miss Millredge, 2nd vice-pres.; P. Osborn, membership convener.

### SASKATCHEWAN

#### SASKATOON

#### *City Hospital*

The annual tea and bazaar of the student nurses' association was held under the auspices of the class of 1957A. Mrs. H. Armstrong, Misses J. Bernie, M. Gibson and E. Klewchuk received the guests. Mrs. D. Wilkie, Misses L. Willis, M. MacKenzie and E. Pearston presided over the tea table. D. Kacsmar and I. Levorson, scholarship students of last year, are attending the University of Saskatchewan. E. Redden and A. Hompoth have joined the staff of the nursing school office as assistant night supervisors.

#### REGINA

Members attending a recent chapter meeting experienced a rare treat in hearing Dr. H. B. de Groot discuss folk music. In the short time at his disposal, Dr. de Groot outlined the evolution of folk music and illustrated with records. Music of the British West Indies, Russia, Spain and Hungary was played. The gypsy music of the latter two countries was especially enjoyable. A short business meeting followed.

#### *General Hospital*

The school of nursing is the proud owner of a new movie projector, with plans to acquire a new slide projector in the near future as well. The gymnasium in the recently completed nurses' residence is much appreciated by both graduate and student nurses as indicated by the increasing activity. Mrs. A. Stewart and Miss M. Lyons attended the institute on "The Role of the Nurse in Civil Disaster" held at Fort Qu'Appelle.



#### *Grey Nuns' Hospital*

The student nurses are planning a special ceremony to welcome a new and modern "Mrs. Chase" into their school. Mrs. H. McCormack and Miss V. Ryan attended the Civil Defence institute held in Fort Qu'Appelle. C. Kenny attended and enjoyed the course held earlier this year at Civil Defence College, Arnprior. D. Percy, Chief Nursing Consultant, Department of National Health and Welfare, visited the school of nursing recently. Mrs. Ellis has resigned from the staff.



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**Superintendent** (Qualified) for new 35-bed hospital. New private suite with telephone. Salary to be arranged. Vacation with pay. Apply stating qualifications with references to Mr. H. R. Wilson, Chairman, Souris Dist. Hospital Board, Souris, Manitoba.

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**Pediatric & Medical Ward Supervisors also General Duty Nurses.** Apply Director of Nurses, Woodstock General Hospital, Woodstock, Ontario.

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**Asst. Director of Nursing** for 200-bed hospital in Niagara Peninsula. Experienced, preferably with University certificate or postgraduate training. Good salary & personnel policies. Please furnish references stating age, qualifications & experience. Apply Director of Nursing, County General Hospital, Welland, Ont.

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**Matron (Experienced)** for 31-bed hospital. Duties to commence as soon as can be. 3 doctors practicing, staff of 22, average daily census 24. Gross salary: \$330 per mo. less \$30 for room & board. 1 mo. vacation with pay after 1 yr. employment. New modern residence with separate matrons suite. Good train service. Apply to J. P. Fawcett, Sec., Union Hospital, Unity, Sask.

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**Head Instructor for Training School to teach Sciences.** 86-bed hospital; 30 students. Complete maintenance provided in comfortable suite. Apply, stating qualifications & salary expected, A. J. Schmiedl, Sec. Manager, General Hospital, Dauphin, Man.

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**Instructor in Nursing.** Faculty position in medical areas, accredited integrated diploma program, northern California college community. Liberal personnel policies, excellent clinical & teaching facilities. Progressive faculty, 90-students. Immediate opening. For details write Personnel Office, 510 E. Market St., Stockton, California.

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**Obstetrical Clinical Instructor** for School of Nursing with capacity 195 students attached to expanding hospital of 571 beds. B.S. Degree in Nursing Education preferred or at least 3 yrs. experience & working towards degree. Located in "all American City" of 120,000 in North Eastern Ohio with educational, industrial, recreational & agricultural primary interests. Salary commensurate with qualifications. Write Director of Nursing, Aultman Hospital, Canton, Ohio.

---

**Clinical Instructor in Obstetrical nursing** for dept. with 26-beds & **Supervisor of Nurseries** for dept. with 30 bassinets. Duties to include teaching & supervision of student nurses. University postgraduate course & experience preferred for both positions. Apply Director of Nursing, General Hospital, Oshawa, Ont.

---

**Nursing Arts Instructor** for School of Nursing, with capacity 195 students, attached to expanding hospital of 571 beds. B.S. Degree in Nursing Education preferred or at least 3 yrs. experience & working toward degree. Located in "All American City" of 120,000 in North Eastern Ohio with educational, industrial, recreational & agricultural primary interests. Salary commensurate with qualifications. Write Director of Nursing, Aultman Hospital, Canton, Ohio.

---

**Instructor** to teach anatomy and physiology, microbiology first term, followed by surgical nursing lectures and clinical supervision on surgical wards. Starting salary: \$255; \$10 for 2 yrs. experience; \$10 yearly increments; 1½ days sick leave, cumulative; 10 statutory holidays; 40-hr. wk; 1 class per yr. in September. Apply to: Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

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SASKATOON, SASK.

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General Staff Nurses for General Hospital with a School of Nursing with 200 students. Salaries starting at \$210 depending on qualifications. Increments of \$5.00 every 6 mo. Bonus for evening & night duty. 44 hr., 5½ day wk. Good Personnel policies.

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SASKATOON, SASK.

**Public Health Nurse Grade 1.** British Columbia Civil Service, Dept. of Health & Welfare. Starting Salary \$255, \$260, \$266 per mo., depending on experience, rising to \$298. per mo. Promotional opportunities available. Qualifications: Candidate must be eligible for registration in British Columbia & have completed a University degree or Certificate course in Public Health Nursing. (Successful candidates may be required to serve in any part of the Province.) Cars are provided. 5-day wk. in most districts. Uniform allowance. Candidates must be British subjects; preference is given to ex-service women. Application forms obtainable from all Government Agencies, the Civil Service Commission, 544 Michigan St., Victoria, or 411 Dunsmuir St., Vancouver 3, to be completed & returned to the Chairman, Civil Service Commission, Victoria. Further information may be obtained from the Director, Public Health Nursing, Dept. of Health & Welfare, Parliament Bldgs., Victoria, B.C.

**Public Health Nurse.** Starting salary: \$2,844 with annual increases over 3 yrs. to \$3,228 per yr. Previous experience qualifies for a higher starting salary. Cost of transportation to Port Arthur refunded after 3 mo. Car allowance or free transportation while on duty. Pension plan after 3 yr. service. Apply stating qualifications & experience to Arthur H. Evans, Secretary, Board of Health, Port Arthur, Ont.

**Public Health Nurses** for generalized program. City of Ottawa, Health Dept. Salary: \$2,760-\$3,240 plus cost of living bonus. Good personnel policies. Superannuation & Blue Cross benefits. Apply Employment & Labor Registry Office, Room 118, Transportation Bldg., 48 Rideau St., Ottawa 2, Ont.

**Assistant Head Nurses** for children's orthopedic hospital. Good personnel policies. Pension plan available. Apply Director, Shriner's Hospital for Crippled Children, 1529 Cedar Ave., Montreal.

**Registered Nurse,** qualified to assist Supt. for 50-bed hospital. Hours chiefly 8:00 A.M. to 4:00 A.M. Apply Supt., General Hospital, Cobourg, Ontario.

**Registered or Licensed Practical Nurse** for Baldur Medical Nursing Unit. Salary: \$175 for reg'd. nurse & \$110 for practical with full maintenance. Apply John Hiscock, Sec. Baldur Medical Nursing Unit, Baldur, Man.

**Registered Nurses for General Duty (2)** for 76-bed fully modern hospital on C.P.R. main line & Trans-Canada Highway to Calgary & Banff. Gross Salary: \$205 per mo., perquisites \$30, \$5.00 increment every 6 mo. 1 mo. annual vacation with pay; 8-hr. day; 44-hr. wk. Sick leave with pay. Apply Matron, Municipal Hospital, Brooks, Alta.

**Registered Staff Nurses,** immediate appointments, in 511-bed newly enlarged and finely equipped general hospital. Duty assignments in medical, surgical, pediatrics, psychiatric, obstetrics, or contagion units. Northeastern Ohio stable "All-American City" of 120,000. In centre of area of recreational, industrial, and educational friendly activities. Living costs reasonable. Within pleasant driving-distance advantages of metropolitan Cleveland and Columbus, Ohio and Pittsburg, Pa. Friendly, cooperative work relations and conditions. Progressively advanced personnel policies. Starting salary: \$240 per mo. with 4 merit increases. Paid vacation, sick leave, recognized holidays, premium pay, sickness insurance and hospitalization program, retirement. Contact: Director of Personnel, Aultman Hospital, Canton, Ohio, by letter or collect telephone 4-5673.

**Registered Nurses for General Duty.** Initial salary: \$200 per mo.; with 6 or more months Psychiatric experience, \$210 per mo. Salary increase at end of 1 yr. 44-hr. wk.; 8 statutory holidays, annual vacation with pay. Living accommodation if desired. For further information apply Supt. of Nurses, Homewood Sanitarium, Guelph, Ont.



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**Registered Nurses for modern 60-bed General Hospital** situated 40 mi. south of Montreal. Salary: \$200 per mo. 8-hr. duty; 44-hr. wk; rotating shifts. Many attractive benefits provided. Board & accommodation available at minimum cost in completely new motel-style nurses' residence. Apply Supt., Barrie Memorial Hospital, Ormstown, Que.

**Registered Graduate Nurses for General Duty** for 650-bed Tuberculosis Hospital, 10 mi. from downtown Toronto. Gross starting salary: \$93 bi-weekly, less \$15.23 for room, meals & laundry. 3 annual increments. 44-hr. wk., 8 hr. day, broken hrs. 3 wk. vacation after 1 yr., 9 statutory holidays. Hospital bus service to & from city. Apply Supt. of Nurses, Toronto Hospital, Weston, Ont.

**Registered Graduate Nurses for General Staff Duty** for 200-bed hospital. Medical-Surgical Units & Obstetrical Unit. Good personnel policies. For further information apply to Director of Nursing, General Hospital, Belleville, Ont.

**Registered General Duty Nurses** for medical & surgical. Rotating shifts, Good personnel policies. Apply Director of Nursing, The Greater Niagara General Hospital, Niagara Falls, Ontario.

**Registered Nurses (3)** immediately for 36-bed General Hospital in southern Manitoba. Starting salary: \$205 per mo. with 3 wk. vacation with pay 1st. yr. employment; 4-wk. vacation thereafter. All statutory holidays. Regular sick leave, 50% Blue Cross payments. Apply Supt. of Nurses, Hospital Dist. No. 24, Box 330, Altona, Manitoba.

**Registered Nurses** for surgery, must be able to scrub & circulate. Starting salary: \$325 per mo. plus other benefits. **Registered Nurses** for general floor duty start at \$300 per mo. plus other benefits. Must be able to get New Mexico registration. 30-bed hospital to move into new 70-bed hospital soon. Apply Supt. of Nurses, Memorial Hospital, Carlsbad, New Mexico.

**Registered or Graduate Nurses for General Duty (2)** for modern 20-bed hospital. Salary & increments in accordance with S.R.N.A. recommendations. 1 mo. vacation & sick time with pay after 1 yr. service. Separate staff residence. Apply Sec.-Man. Riverside Memorial Hospital, Turtleford, Sask.

**Registered Nurses for General Duty Staff.** Salary commences at £40-10-0 per mo. with full maintenance. Transportation allowance. For full particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

**Graduate Nurses** for 100-bed West Coast General Hospital. Salary: \$250 per mo. less \$40 for board, residence, laundry. 3 annual increments; \$10 per mo. night duty bonus. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. cumulative to 36 days. Transportation allowance up to \$60 refunded after 1 yr. Apply Director of Nursing General Hospital, Prince Rupert, B.C.

**Graduate Nurses (3)** for 24-bed hospital. Salary: \$230 per mo. if B.C. registered; less \$40 board, lodging, laundry. 1 mo. vacation after 1 yr. on full pay. 1½ days sick leave per mo. cumulative. Apply, stating experience to Matron, Terrace & District Hospital, Terrace, British Columbia.



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**General Duty Nurses** for small hospital. Salary: \$200 per mo. plus maintenance. 8-hr. day, 44-hr. wk., statutory holidays as outlined by R.N.A.O. Travelling expenses refunded after 12 mo. service. New nurses' residence under construction. Apply Lady Minto Hospital, Chapleau, Ontario.

**General Duty Graduate Nurses** for well equipped 72-bed hospital on B.C. coast. Salary: \$222 per mo. less \$25 full maintenance. Semi-annual increments. 28 days vacation plus 10 statutory holidays after 1 yr. Apply Matron, St. George's Hospital, Alert Bay, B.C.

**General Duty Nurses for Medical, Surgical, Pediatrics, Obstetrics.** Good salary & personnel policies. Apply Director of Nursing, Victoria Hospital, London, Ont.

**General Duty Nurses** for all departments. Gross salary: \$210 per mo. if registered in Ontario \$200 per mo. until registration has been established. \$20 per mo. bonus for evening or night duty; annual increment of \$10 per mo. for 3 yrs. 44-hr. wk., 8 statutory holidays, 21 days vacation & 14 days leave for illness with pay after 1 yr. of employment. Apply: Director of Nursing, General Hospital, Oshawa, Ont.

**General Duty Nurse** for well equipped 80-bed General Hospital in beautiful inland valley adjacent Lake Kathryn. Boating, fishing, swimming, golfing, curling, skiing. Initial salary: \$240, full maintenance, \$40. 44-hr. wk. vacation with pay. Comfortable, attractive nurses' residence on grounds. Rail fare advanced if necessary, refunded following 1 yr. service. References required. Apply Bulkley Valley Dist. Hospital, Smithers, B.C.

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**General Duty Nurses for 650-bed teaching hospital** in central California. Salary: \$288-\$337 per mo. 40-hr. wk. Liberal vacation, holiday & sick leave plan. Apply Personnel Office, 510 E. Market St., Stockton, California.

**General Duty Nurses.** Salary: \$230-270, \$10 increment for experience. 40-hr. wk. 1½ days sick leave per mo. cumulative; 10 statutory holidays, (1) mo. vacation. Must be eligible for B.C. registration. Apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

**Staff Nurses for 600-bed General & Tuberculosis Hospitals with School of Nursing.** Salary: \$288-\$341. Shift, special service & educational differentials, \$10. 40-hr. wk; 3-wk. vacation; 11 holidays; accumulative sick leave. Apply Associate Director of Nursing Service, County General Hospital, Fresno, California.

**Staff Nurses & Operating Room Scrub Nurses** for 225-bed General Hospital, 20 mi. north of New York City. Salary: \$240-\$280. \$20 extra for O.R. duty & permanent evening duty; \$15 for permanent night duty. Apply Director of Nursing, St. John's Riverside Hospital, Yonkers, N.Y.

**Operating Room Nurses,** immediate appointments, for 511-bed newly enlarged and finely equipped hospital; 10 operating rooms now completed. Northeastern Ohio stable "All-American City" of 120,000. In centre of area of recreational, industrial and educational friendly activities; living cost reasonable. Within pleasant driving-distance advantages of metropolitan Cleveland and Columbus, Ohio, and Pittsburg, Pa. Friendly and considerate working associates and conditions. Progressively advanced personnel policies. Starting salary: \$240 per mo. with 4 merit increases. Paid vacation, sick leave, recognized holidays, premium pay, sickness insurance and hospitalization program, retirement. Contact Director of Personnel, Aultman Hospital, Canton, Ohio, by letter or collect telephone 4-5673.

**Operating Room Nurses,** preferably with experience, for 75-bed hospital. Operating unit consists of 2 theatres, emergency treatment & recovery room. Apply Supt., Carleton Memorial Hospital, Woodstock, N.B.

**Operating Room Nurses (Immediately).** Rotating shifts, good personnel policies. Apply Director of Nursing, The Greater Niagara General Hospital, Niagara Falls, Ontario.

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**Maternity Nurses for modern 60-bed General Hospital** located 40 mi. south of Montreal. Salary: \$155 per mo. 8-hr. duty; 44-hr. wk; rotating shifts. Many attractive benefits provided. Board & accommodation available at minimum cost in completely new motel-style nurses' residence. Apply Supt., Barrie Memorial Hospital, Ormstown, Que.

**General Staff Nurses** for 400-bed Medical & Surgical Sanatorium, fully approved student affiliation & postgraduate program. Full maintenance. Recreational facilities. Vacation with pay. Sick benefits after 1 yr. Blue Cross coverage. Attractive salary; 40-hr. wk. For further particulars apply Supt. of Nurses, Nova Scotia Sanatorium, Kentville, N.S.

**Baker Memorial Sanatorium, Calgary, Alberta,** offers to Graduate Nurses a 6-mo. post-graduate course in Tuberculosis. Maintenance & salary as for general staff nurses. Opportunity for permanent employment if desired. Spring & Fall Classes. Further information on request.

**Registered Laboratory Technician** (Experienced) would like position in small hospital laboratory. Ontario or B.C. preferred. Available 1 mo. Apply The Canadian Nurses, Box M, 1522 Sherbrooke St. W., Montreal 25, Que.

**Dietitian** (qualified) for Teaching Hospital. Opportunity for advancement. Full maintenance. Fare from Canada for accepted candidate. For full particulars, write, giving qualifications & date available, Matron, King Edward VII Memorial Hospital, Bermuda.

**Office Nurse** with commercial training required for doctor's office January 1956. Must have ability to take full responsibility for running large office practice in St. Catharines. Apply Box J, The Canadian Nurse, 1522 Sherbrooke St. W., Montreal 25, Que.

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**Asst. Superintendent & General Duty Nurses** for 35-bed hospital, 50 mi. from Toronto. Good salary & personnel policies. Please furnish references & apply to Supt., Stevenson Memorial Hospital, Alliston, Ont.

**Operating Room Supervisor** for Ontario active surgical unit of 100-bed hospital. Approx. 1,800 cases annually. Vacation after 1 yr. of service. Sick leave, statutory holidays & Blue Cross Plan. Postgraduate diploma desirable but not necessary if experience is adequate. Apply The Director of Nursing, Cottage Hospital, Pembroke, Ont.

**Graduate Registered Nurses** for general duty for 118-bed General Hospital along the shores of Lake Michigan, 25 mi. from Chicago. Base salary \$300. Good personal policies. Apply Highland Park Hosp., Foundation, 718 Glenview Ave., Highland Park, Ill.

**Registered Nurses** for 82-bed accredited hospital. Gross Salary: \$210-\$230 per mo. 44-hr. 5½-day wk. with no split shifts. 30 days vacation with pay after 1 yr. of service plus statutory holidays. Room in a comfortable residence & laundry of uniforms provided at \$10-\$12 per mo. Apply Supt. of Nurses, Union Hosp., Canora, Sask.

**General Duty Nurses** for 40-bed hospital. Salary \$250, full maintenance \$45. 42-hr. wk., 28 days annual vacation plus 10 statutory holidays. Rotating shifts, cumulative sick leave, self-contained residence. Apply Director of Nursing, General Hospital, Princeton, B.C.

**General Duty Nurses** for Pediatrics, Medical, Nursery & O.R. **Scrub Nurse** for new 165-bed hospital plus 35-basinettes. Excellent salary & generous personnel policies. Apply Director of Nursing, General Hospital, Pembroke, Ont.

**General Duty Nurses** for 114-bed hospital. Salary: \$220-\$250 with \$5.00 increments every 6 mo. 44-hr. wk., 3-wk. annual vacation, statutory holidays etc. For further particulars please apply to Director of Nurses, Union Hosp., Swift Current, Sask.

**Industrial & Public Health Nurse**, experience desirable but not essential for Company with 350 employees. Located in mid southwestern Ont. Familiarity with all phases of Workmen's Compensation would be an asset but not essential. Usual company benefits including Group Life, Blue Cross & P.S.I. Good and congenial working conditions. Apply by letter stating experience, salary expected & when available to Hay & Co. Ltd., Woodstock, Ont.

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270 Laurier Ave., W., Ottawa

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# THE CANADIAN NURSE

## *L'Infirmière Canadienne*

VOLUME 52

NUMBER 3

MARCH 1956

- 166** NEW PRODUCTS
- 173** FORTY YEARS OF PILGRIMAGE.....*E. K. Russell*
- 175** THE SOCIAL SCIENCES AND IMPROVEMENT  
OF PATIENT CARE.....*E. L. Brown*
- 180** THE DISTRICT NURSE KNOWS BETTER.....*M. Kirk*
- 183** PSYCHIATRIC NURSING.....*E. Bregg*
- 185** FUN ON TRAINS.....*M. Steed*
- 187** NURSES AS TEACHERS OF SCIENCE.....*A. E. Reid*
- 191** AN ORDERLY TRAINING PROGRAM.....*M. L. Richmond*
- 193** MECONIUM ILEUS.....*D. Wright and J. Bullock*
- 196** LA SOCIÉTÉ DES INFIRMIÈRES VISITEUSES.....*R. Rivard*
- 197** MY COMPLAINTS.....*A. Dalton*
- 199** NURSING PROFILES
- 200** IN MEMORIAM
- 202** NURSING ACROSS THE NATION
- 204** LE NURSING À TRAVERS LE PAYS
- 206** SÉLECTION
- 214** CONVENTION PERSONALITIES
- 216** BOOK REVIEWS
- 224** NEWS NOTES

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# Between Ourselves

LAST SUMMER A CONFERENCE was held at National Office when there was considerable discussion regarding the topics that would probably generate greatest interest in the forthcoming convention. Everyone would want to know about costs so Ethel Armstrong Collins, convention coordinator of the CNA, was assigned the task of securing information from the railway companies and the airlines about fares. That information was published last October, together with a preliminary description of some post-convention tours. Following the 1954 convention, the arranged tours proved so popular that Mrs. Collins has spent a great deal of time perfecting arrangements for the vacation trips this year. Considerable supplementary material regarding them was published last month.

The two special trains from Eastern Canada to Winnipeg have been well-publicized both at provincial annual meetings and through the *Journal*. This month, **Margaret Steed** tells us of the enjoyment of the hundreds of nurses who travelled on the "Nurses Special" in 1954.

As everyone knows by now, the theme of this year's convention is "Nursing Serves the Nation." Alice Girard, chairman of the CNA Nursing Service Committee posed some thought-provoking questions relating to this theme last month. "But basic to good nursing service," ran the discussion at last summer's conference, "is nursing education. In stressing our theme this year, we must not let it completely overshadow the importance of a sound educational program to provide the highly qualified nursing staffs to give the service."

Though she has retired from the School of Nursing of the University of Toronto where, after more than 30 years, her dynamic leadership has left an indelible mark, **E. Kathleen Russell** has by no means retired from active interest and participation in nursing education. Shortly after completing an interim evaluation of the centralized nursing program at the University of Saskatchewan last year, Dr. Russell was appointed by the University of New Brunswick to make an intensive study of the schools of nursing in that province.

Dr. Russell's interest has never been confined to any one school. On the contrary, she has always conceived of nursing education as being the medium through which

improved community service might be effected. She was one of the first to advocate a survey of nursing education in Canada and served as a member of the joint committee that guided the project some 25 years ago. We are delighted to welcome her as our guest editor this month.

\* \* \*

As has often been said in the course of talks about our *Journal*, there is a very varied reader audience for every issue. This audience ranges from the more senior group in administrative and executive positions through the vast throng of staff nurses in every branch of our profession to the eager youngsters who are the students in our schools of nursing. It includes hundreds of nurses who are no longer active participants in the hospitals and public health organizations but who nevertheless are valued workers in the chapters and district associations — the associate members who are always eager to know what is going on in the nursing world. Each issue is planned with this wide span of reader interest in mind.

This month we welcome to this readership all of the active and associate members of the Registered Nurses' Association of Nova Scotia. You will find mental stimulation in the challenging address of Dr. **Esther Lucile Brown**, in the discussion of developments in the program of two Canadian university schools of nursing, in the analysis of what psychiatric nursing really is. Good reading, friends!

\* \* \*

Those Canadians whose good fortune it was to receive Florence Nightingale Foundation fellowships probably have all received copies of the new book, recently published by the League of Red Cross Societies, "The Lamp Radiant." This is a fascinating story of the inception, development and postwar achievements of that illustrious group of "Old Internationals" whose memories of war-destroyed 15 Manchester Square, London, remain ever fresh. Others who are interested in securing this small history may order it from the League at 26 Avenue Beau-Séjour, Geneva, Switzerland. The price is 80 cents.

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We judge ourselves by what we feel capable of doing, while others judge us by what we have already done. — LONGFELLOW



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# New Products

Edited by DEAN F. N. HUGHES

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## BIONET DROPS

**Manufacturer**—Frank W. Horner Ltd., Montreal.

**Description**—Contains: Bicetonium (cetyl dimethylbenzyl ammonium chloride) 0.025%, methapyrilene HCl 0.25%, ephedrine HCl 0.50%, hydrocortisone 0.02%.

**Indications**—Allergic rhinitis, acute and chronic rhinitis, nasopharyngitis and sinusitis.

**Administration**—To be sprayed or dropped into nostrils as prescribed.

---

## BUTISOL

**Manufacturer**—McNeil Laboratories, Philadelphia; Can. Dist.: Van Zant & Co. Ltd., Toronto, Ont.

**Description**—Butisol repeat action tablets, each containing 30 mg. butisol sodium (sodium 5-ethyl-5-sec-butyl barbiturate), 15 mg. in the outer coat for immediate release and 15 mg. in the specially coated core for delayed action.

**Indications**—Conditions requiring mild prolonged sedation such as: Essential hypertension, coronary disease, congestive heart failure, premenstrual tension, menopause, anxiety neuroses, etc.

**Administration**—One dose affords a sustained sedative effect for 8 to 12 hours. Dosage is 1 or 2 tablets 2 or 3 times a day.

---

## COLISONE

**Manufacturer**—Charles E. Frosst & Co., Montreal.

**Description**—Brand of prednisone, anti-inflammatory and antirheumatic agent said to be 3-5 times as effective as cortisone or hydrocortisone. Scored tablets of 5.0 mg.

**Indications**—Collagen diseases — as for cortisone.

**Administration**—Initially, 20 to 30 mg. daily by mouth in divided doses after meals and before retiring. Higher doses may sometimes be indicated. Maintenance doses range from 5 to 20 mg. daily.

---

## DICOSAL

**Manufacturer**—H. Powell Chemical Company Ltd., Bowmanville, Ont.

**Description**—Compressed tablet containing: Salicylamide (6 gr.) 390 mg., secobarbital sodium (1/4 gr.) 16 mg., dihydrocodeinone bitartrate (1/8 gr.) 8 mg.

**Indications**—As an analgesic and sedative for the relief of pain symptoms of migraine, neuralgia, severe headache, dysmenorrhea, muscle and joint pains.

**Administration**—One tablet every three or four hours.

---

## GAMADYNE No. 1. No. 2. No. 3

**Manufacturer**—Gama Pharmaceuticals Ltd., Toronto, Ont.

**Descriptions**—Each capsule contains:

	No. 1	No. 2	No. 3
Acetylsalicylic Acid .....	5 gr.	5 gr.	5 gr.
Phenacetin .....	2 gr.	2 gr.	2 gr.
Caffeine Citrate .....	1/2 gr.	1/2 gr.	1/2 gr.
Codeine Phosphate .....	1/8 gr.	1/4 gr.	1/2 gr.

**Indications**—Analgesic, anodyne, antipyretic.

**Administration**—One or two capsules as directed by physician.

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## GAMATUSS

**Manufacturer**—Gama Pharmaceuticals Ltd., Toronto, Ont.

**Description**—Each fl. oz. contains: Codeine phosphate 1 gr., sodium citrate 25 gr., ammonium chloride 16 gr., potassium iodide 16 gr., chloroform 1.6 m. in a palatable flavored base.

**Indications**—Expectorant and respiratory sedative.

**Administration**—One or two teaspoonfuls every four hours. Children, according to age.

---

## GOLD SODIUM THIOSULPHATE

**Manufacturer**—Abbott Laboratories Limited, Montreal.

**Indications**—For the treatment of lupus erythematosus.

**Administration**—Solutions of this gold salt are unstable. They should be freshly prepared before using.

**Dosage**—The preferred initial dose is 5 mg. given intravenously in 2 to 5 cc. of sterile distilled water. Subsequent doses given at weekly intervals are increased 5 mg. per dose to a maximum of 50 mg. for women and 75 mg. for men provided no reactions have occurred.

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Hamilton, Ontario.**



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**Description**—Each scored tablet contains penicillin G potassium 500,000 I.U. formulated so that disintegration occurs in the small intestine.

**Indication**—Treatment and prevention of infections due to penicillin-sensitive organisms.

**Administration**—Therapeutic — 2 or 3 tablets daily are usually adequate except in bacterial endocarditis, meningitis and staphylococcic sepsis.

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### INFLUENZA VIRUS VACCINE POLYVALENT

**Manufacturer**—Lederle Laboratories Division, North American Cyanamid Ltd., Montreal.

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**Administration**—Subcutaneously or intramuscularly. This vaccine should not be injected intravenously.

**Dosage**—Adult: 1 cc. Children under 12 years of age: Dose should not exceed 0.5 cc. with proportionately less for the very young. Booster injection: 0.5 cc. if unusual epidemic conditions exist. The booster injection should be given preferably 6 months to 1 year after basic immunization.

---

### LIQUID SOBEE

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**Description**—Made from water, soybean, flour, dextromaltose, sucrose, soybean oil, coconut oil, calcium carbonate, sodium chloride, dicalcium phosphate, chondrus extract, vitamin A palmitate and calciferol.

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### NEUTRA DETERGENT CAKE

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**Indications**—For soap-sensitive skin, acne and whenever thorough cleansing of skin is indicated.

**Administration**—Use instead of soap.

---

### NEUTRATAR SHAMPOO

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**Administration**—Adults, usually 2 tablets 4 times daily. Children, according to age and ability to swallow tablets.

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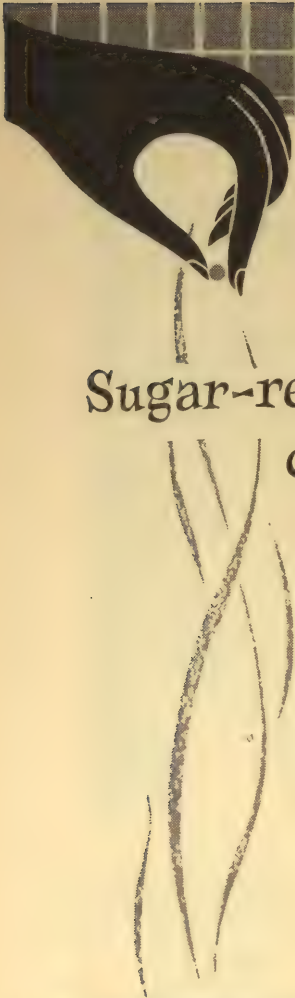
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# THE CANADIAN NURSE

## *L'Infirmière Canadienne*

A MONTHLY JOURNAL FOR THE NURSES OF CANADA  
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## Forty Years of Pilgrimage

The Canadian Nurses' Association has announced the topic for the coming biennial meeting to be held in Winnipeg in June. "Nursing serves the nation" is the general theme around which the whole program has been constructed. But, broad as this subject is, it must submit to even further expansion: inevitably nursing service precipitates us into the allied question of nursing education, for it is well known that the service of any profession finds its level in the schools that prepare the workers. So we are now faced with the two seemingly separate, and yet completely interdependent, approaches to our field of professional work.

For the past twenty-five years there has been increasing effort to change the structure and pattern of nursing schools in order to give competent preparation for adequate nursing service to contemporary society. The concerted effort in this direction, in Canada, might be dated from the publication of the Weir Report in 1932. With what success? It would be quite wrong to discount real accomplishment, but equally wrong to ignore the increasing confusion as new patches

are added to the old garment of nursing education. Now Canadian nurses are asking insistently for the explanation of this delay and are determined to overcome all obstacles and to pursue the matter, in season and out of season, until they see the fundamental recon-



E. KATHLEEN RUSSELL



struction that must come. Nursing as it was adapted to nineteenth century medical, hospital and social conditions is unable to serve the extraordinarily different conditions of the mid-twentieth century. Sighing for past glory — real or imaginary — is merely a waste of time.

Undoubtedly nursing education presents an extremely difficult task, inherently complex and dogged by reactionary influences. Unfortunately, it is being made even more difficult by the tendency to over-simplification of the whole question. It is not simple, and cannot be made simple, but it must be possible to outline the total objective and to prepare a blue print for constructive action. Note that we speak of the *total* objective. Piecemeal change may make matters worse than before and yield only diminishing returns. A simple illustration is found in the fact that the eight-hour day for nurses has left the hospital patient more isolated than ever. Certainly, a return to the old twelve-hour period of duty is neither desirable nor possible. A deeper search must be made for the answer to this and many other questions.

Editorial comment must of necessity be brief. It is only possible now to add that many problems present themselves in the pursuit of our total educational objective but perhaps three may be cited as indicative of the task that lies ahead. The first of the three has been suggested already, namely, the adjustment needed in hospitals in order to give nursing to the patient. With intent we ask tersely for nursing, not for "nursing care" or "nursing the patient as a person." These expressions can become so hackneyed that they tend to obscure thought or to serve as substitutes for thought.

The following facts have been brought to light in a recent study of hospital morbidity in Ontario. The results are based mainly on hospitalization reports for 1951.

The men outnumbered the women in the incidence of such conditions as gastric ulcers, arteriosclerotic heart disease, displacement of intervertebral disc and alcoholism. The women showed a greater tendency towards diabetes mellitus, diseases of the thyroid

The patient may be represented as a small island, one among many in the hospital sea. A fleet of nursing boats and auxiliary craft ply to and from the island throughout the twenty-four hours, carrying very necessary cargo of divers shapes and sizes; but no boat can pause long in its rapid voyaging so none really knows the island, though the passive island itself comes to recognize — more or less — a few of the craft that happen to call a bit more frequently than others. Is this a distorted description or merely a bit of exaggeration to give emphasis? If essentially true, the import of it all to the patient — and the doctor and the nurse — cannot be stressed too greatly. And could it be that the young student is learning thereby to expect not to know her patients — and this at the most impressionable stage of her clinical training?

A second task is to obtain acceptance throughout the nursing world for the fact that public health nursing is real nursing, just as truly as is hospital nursing. With this acceptance, preparation for health practice will be given more adequate attention from the beginning of the basic professional course.

Perhaps the final place in this selected trio should be given to the tremendous challenge of finding and preparing even a tiny company of directors of nursing schools, and of teaching staff, ready to lead their followers into the promised land even if it entails forty years of pilgrimage. For comfort, it might be considered that nearly twenty-five of those years have been checked off already!

KATHLEEN RUSSELL,  
B.A., B. PAED., D.C.L.  
*Professor Emeritus,  
University of Toronto*

gland, migraine headache and varicose veins. They are more likely to become anemic and outrank the men eight to one in developing bunions! Flat feet and hay fever affect both sexes with equal intensity.

— *Hospital Morbidity Study,  
Province of Ontario*

\* \* \*

The Canadian Red Cross Society will celebrate its 50th Anniversary in 1959.

# The Social Sciences and Improvement of Patient Care

ESTHER LUCILE BROWN

THE TWENTIETH CENTURY, particularly the decade since the end of World War II, has seen a vast expansion of hospitals, outpatient clinics, health agencies, and bodies charged with planning for the health services in large parts of the Western world. The magnificent new University Hospital in Saskatoon takes its place among the proud guardians of what modern medical science and hospital construction and administration have been able to achieve. I speak, however, not of hospital buildings as such, of the achievements of the biological and physical sciences, nor of the practice of medicine in which I have no competence, but of patient care as it is provided within the hospital and as it is experienced by the patient.

For some 15 years now there has been increasing concern both by the staffs who provide that care and by the patients who experience it lest we be failing even to maintain standards comparable to those that existed prior to the past war. In techniques for diagnosing, treating, and preventing disease we have shown preeminent success. But what about relationships with patients, and the contribution of those relationships to the healing process? Let us take a brief look at patient care as it would probably appear to social scientists as well as to many members of the health services, who visited a succession of large general hospitals that had well-established reputations in diagnosis and treatment of disease and laboratory research.

1. Observation of floors or wards would reveal much movement, often hurried and sometimes confused, by

staff of many different categories, including several new groups of assistant personnel. Almost everyone would be carrying out a procedure ordered by the appropriate person in the service with which he was associated. Even if he were a member of the regular ward staff and not from another department, however, he would rarely seem to be part of a *team* whose efforts had been closely coordinated in behalf of helping patients to manage the problems of illness, particularly psychological problems. Very infrequently would one see the members of the ward staff sitting down together at a conference table for regular and systematic discussion of the needs of individual patients and how those needs could best be met.

Patients report that they find the stream of personnel who do something *to* them or *for* them but rarely *with* them, extremely disconcerting and fatiguing. Instead of gaining psychological support they have a sense of vast aloneness, and often an increase of anxiety. When ward staff is asked whether group planning could not lead to reduction in the number of personnel serving a particular patient, and whether it is not possible for someone — physician or nurse — to sit down quietly with, and listen to, the patient for a few minutes each day, the questioner is promptly told that present deficits in ward care are the result of serious numerical shortages, particularly of nurses. That grave shortages exist in many geographical areas that have been rapidly expanding their medical and health services, as well as in practically all psychiatric hospitals, is factually correct, but to make these shortages bear so large a responsibility for inadequacies is to preclude examination of other essential factors.

2. The average general hospital is still organized to take care almost exclusively of patients who are in bed, although early ambulation has greatly reduced the nature of hospitalization.

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Dr. Brown is on the executive staff of the Russell Sage Foundation, New York. She gave this paper as one in a series of addresses presented at the opening of The University Hospital, Saskatoon, Sask., last May. Several of these addresses are being published this month in *The Canadian Hospital*.



The social scientist is surprised at the absence of convenient lounges furnished with books, magazines, and games, and the absence of facilities for showing films, serving tea, or providing other social activities. From the lessons learned by psychiatric hospitals, pediatric and rehabilitation services, are we not to conclude that all ill patients need a social environment more nearly resembling that of the home and community which would give them some sense of contact with the outside world, some distraction from preoccupation with illness, and would perhaps reduce the demands for service made upon the ward staff? If there be a shortage of personnel, could a social setting not be created that would minimize this inadequacy somewhat, and would allow patients themselves to give more psychological help to other patients?

3. Although large numbers of persons are employed in doing something *to* or *for* the patient, examination of ward care reveals that systematic plans for teaching patients how to care for themselves after leaving the hospital, or facilities for the maximum rehabilitation possible while in hospital, are rare indeed. Many individual patients certainly receive excellent instruction from physician or nurse, and an increasing number of hospitals are concerned with problems of rehabilitation. But for numberless other patients responsibility appears to end when the acute phase of the illness is over. Everyone is so well acquainted with the serious consequences for the patient, in discomfort, anxiety, and often needless readmission to the hospital that no illustrations are necessary. The question is, why is it impossible to provide at least the essential guidance, even if rehabilitation cannot be supplied? The answer probably lies chiefly in the fact that there is no clear allocation of responsibility among personnel about who is to do the teaching, or insufficient supervision, if responsibility has been assigned, to guarantee that the teaching will be consistently performed. And the reason for failure to determine who shall assume the responsibility is rooted, in considerable part, in the inadequacy of communication that exists among the categories of staff concerned with patient care.

4. This last conclusion brings us immediately to one of the most serious problems in its consequences for patient care, but one of which physicians particularly seem so little aware that something must be said about it in greater detail. It is the distressing lack of communication between the two professions most directly and intimately in contact with the patient, namely the doctor and the nurse. So incredible does this phenomenon appear to the social scientist when he first begins objective observation of hospitals, that one sociologist periodically stationed himself near the charge desk on various wards to count the number of exchanges — of no matter what nature — between these two groups of staff. His count showed that physicians spoke to physicians, even at the head nurse's station, *eight times* as frequently as they spoke to nurses. If this occurs in a fine voluntary hospital that prides itself on administrative competence, is it any wonder that a lay board member of another hospital characterized this social distance between the two groups as a "barren no-man's land"?

What are the consequences of such failure in communication for the patient? One brief illustration will have to suffice. In a particular hospital that I was visiting, it was suggested that I talk to the head nurse of a ward for veterans with long-term illness, so exceptionally competent and highly motivated was she in the care of chronic patients. In describing the various patients and the nursing problems presented, she came to the name of Mr. M.

"Last night he told the nurse," said she, "that he did not expect to live. We had no idea that he had anxiety about dying, particularly when his condition is so much better than that of other patients."

"And what has been done to relieve Mr. M. of anxiety?" I inquired.

"The night nurse reported it to me and I have reported it to the resident," was the reply.

"Do you know whether the resident has already had a talk with Mr. M.?" I queried. She did not know.

"Do you think he will talk with Mr. M. — and very soon?" She refused to hazard an opinion. When I inquired



what she considered her responsibility, knowing as she did that a patient was afraid he was going to die, she only said again that she had reported the matter promptly.

"But couldn't you ask the resident, with a smile, 'Did you remember to see Mr. M.?'"

To this she answered, "You have been discussing with us in the hospital the value of ward staff meetings at which we could talk about the management of patients. If we are able to start such meetings, problems like that of Mr. M. can be taken up."

The only difficulty with the proposed solution was that such meetings would not be instituted for weeks at best, and Mr. M. was suffering anxiety. Here was a thoroughly experienced nurse whose interpersonal relations with patients, as I watched her, appeared so excellent that she could probably have allayed Mr. M.'s fears in short order. Yet she did not feel free to assume that responsibility or even to make certain that the resident physician had assumed it. We can only infer that the institutional system of the hospital, a subject to which we shall return soon, had produced this strange pattern of behavior.

5. Detailed observation of patient care and interviews with personnel lead to the conclusion that motivation is often inadequate and morale low among many members of ward staffs. So poor indeed does motivation frequently appear that we must ask whether the roots of the present problems do not lie here quite as much as in numerical shortages. In hospital after hospital that is favored with relatively large staffs, excellent equipment, and facilities of the traditional kind, administrators admit that if only the resources in personnel and equipment could be fully mobilized patient care would probably be greatly improved.

When members of the staff are interviewed by a social scientist in whom they have confidence, recurring opinions and emotions are expressed that perhaps explain the half-hearted interest. If these opinions are sorted and arranged according to their frequency, the interviewer is likely to discover that above everything else staffs want to be found fault with

less when the fault lies really in the hospital system rather than in their own neglect or shortcomings. Generally in second place is the desire by the staff for recognition in the form of a word of praise or a smile when something has been done well. Relatively high on the list is the expression of need for stronger support from ward physicians or supervisory nurses in frustrating and anxiety-provoking situations. Parallel with the expression of need for support, however, is the desire to be consulted about patients' behavior or what could be done to improve ward conditions. Interestingly, higher pay and shorter working hours, that management often concludes are workers' chief interest, are likely to be well down the list — and that in spite of the low salary scale of hospitals generally.

What hospital employees who work most closely with patients want, therefore, is much like what most workers elsewhere want: the sense that what they are doing is important, and that it is recognized as such both by those higher in authority and by their own category of staff. They want that recognition to be demonstrated in positive terms not only of praise and of being asked for opinions concerning ward matters with which they are well acquainted, but they want to be given the feeling that they are part of a group therapeutic effort. In the failure of the hospital to supply these basic needs of its employees may lie an essential reason for patient care being so impersonal and hurried, and neglectful of other than technical procedures. Is it not possible that floor staffs have lived in a cold, sterile atmosphere that has chilled them to the bone until they in turn reflect that atmosphere in their stiff and starched relations with patients?

6. This question brings us to the last point in this array of observations. The social scientist notes research laboratories where productive efforts are being made to further diagnostic and therapeutic goals. But he rarely finds comparable research concerned with assessment of the quality of patient care, with development of techniques for increasing effectiveness of relations between staff members and between staff and patients, and with

evaluation of the results achieved. In a manuscript recently submitted to Russell Sage Foundation for publication, one of the authors has written the following paragraph about a hospital that for a decade has pioneered in studies of improvement of patient care.

As late as 1943 there was little research that tended to increase self-awareness: understanding of the manner in which each individual in the hospital setting was functioning, how he was contributing to therapeutic goals, and how his contribution might be implemented further. Although a few things within the hospital system were well studied, the system itself escaped notice, and (social science) research was not an integral part of the system.

Research of the kind to which Dr. Milton Greenblatt refers has as yet been slight. What has been learned, however, from the application of concepts of behavior to the field of industrial management alone furnishes sufficient guide lines for initiating hospital research and experimentation. J. A. C. Brown, a British psychiatrist, has simply and clearly synthesized this knowledge in "The Social Psychology of Industry," published in 1954 by Penguin Books. Dr. Brown's discussion of morale and the impetus that causes men to want to work is almost as relevant for the hospital as the industrial plant. If the analysis made by social scientists who have studied institutional organization be applied to large complex hospitals, the cause for the frequent failure to supply the basic needs of employees becomes apparent.

That cause is the traditional and inflexible nature of the formal social structure of the hospital. Let us think of it for a moment as it would appear on an organizational chart. The chart would show parallel horizontal lines representing authority and status. At the top of the structure would be the board of trustees; at the bottom, so far as direct patient care is concerned, would be the aide or orderly. The chart also would show parallel vertical lines representing functions or services, such as the medical, social work, nursing, or physiotherapy service. At the top of each of these vertical lines would be the persons responsible for planning and administering the service; at the bottom, those responsible

for carrying out orders at the point of immediate contact with patients. Within this organizational structure everyone would function within a relatively well-defined area, and those numerically very important groups at the bottom of the hierarchy, within closely circumscribed areas.

This limitation to functional movement either upward or outward is accentuated, moreover, by the fact that communication moves primarily only in one direction — from persons with more authority and higher status to those with less — and the communication is phrased largely as orders, pronouncements, and announcements. Few plans or even suggestions and pertinent information flow in the other direction, while reasonable requests for supplies or repairs often move so slowly and with such distortion along extended lines of communication that patients and floor staff conclude that "the hospital" is not interested.

The effect of the formal organization of the large hospital, thus analyzed, is obviously the opposite to what would be required were floor staffs to be given recognition, a feeling of importance, and a sense of contributing to a group therapeutic effort. The problem becomes, therefore, one of striving to discover how these two apparently irreconcilable sets of factors may be more nearly harmonized. Some hospital administrations have rather naively assumed that if increased praise and decreased blame of ward personnel would improve morale and efficiency, little more was required than a suggestion to those in positions of authority that they alter their behavior when on the wards. Unfortunately, behavior patterns are not likely to be changed, or remain changed, if the social organization continues inflexible and no attempt is made to re-evaluate and restructure the roles ascribed to the lower echelons of personnel.

Recently a few hospitals have experimented with altering relationships among staff by creating situations that foster less reliance upon authority and status and more upon coordinated group effort. The results have been promising enough to encourage these hospitals to attempt to discover how such situations can be expanded in



number and scope and made to contribute the maximum possible to breaking down harmful barriers.

Space permits illustrative reference to only one type of situation. The weekly or semi-weekly ward-staff conference has been selected because most persons have some acquaintance with it and it has proved potentially useful in improving patient care. Although it has been employed in many places for discussion of management of patients or altering ward conditions, it is capable of greater effectiveness and of serving more ends simultaneously than has generally been supposed. Success has frequently been limited because the resident physician did not attend, monopolized the discussion, or kept reverting to considerations of diagnosis and treatment; because only the morning shift was represented or aides and orderlies were not included. If a total staff be present and a permissive atmosphere cultivated, such meetings are capable of encouraging movement on several fronts concurrently. The discussion of patient care and ward conditions is extremely valuable in itself. But an opportunity has also been provided whereby anxieties can be expressed and support offered; frustrations and annoyances aired and often resolved; personnel who have never before uttered an opinion helped to participate and thereby to develop greater occupational competence; and the entire staff gradually woven into a closely coordinated team of workers.

In a project on improvement of pa-

tient care in large psychiatric hospitals that Russell Sage Foundation lately sponsored and the results of which will shortly be published, the ward psychiatrists for the selected experimental areas concluded that they could not raise the level of care appreciably unless the ward staffs were individually and collectively taken into full partnership. The ward-staff meeting was one of the chief instruments employed for creating and maintaining that partnership. I wish I could report in detail on the changes that were achieved in a few months. It is only possible to note that changes were of an order that made many visitors hesitant to believe that these were the same wards and the same staff they had seen prior to the beginning of the project. Motivation ran so high that the personnel vied with each other to see who could think of more or better ways to improve conditions; one physician, in particular, was subjected to great pressure to initiate further undertakings. Almost all staff reported to the social scientist who acted as observer that they were more interested in and satisfied with their work than they had ever been before. One supervisory nurse stated that in his 14 years of psychiatric nursing he had heard much talk of the team, but this was the first time he had ever seen it practised. Best of all, improvement of even long-time chronic patients was pronounced, and both patients and their families showed far more satisfaction with the hospital than formerly.

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## Fluoridation

The effect of fluoridation in reducing the rate of tooth decay has been graphically illustrated by the results of a 10-year experimental study in an Ontario town.

The purpose of the experiment was to determine whether the mechanical adjustment of the fluoride content of the water supply would reduce the rate of tooth decay to the lower level found in regions where drinking water contains fluoride naturally. The result was "a significant decrease, amounting to 60 per cent in the number of decayed, missing and filled teeth" suffered by school children of the area. It has been

established that there is nothing to indicate that this practice is harmful to persons of any age. On the contrary it appears that introduction of fluoride is both harmless and beneficial.

The cost of water fluoridation in the experimental area, where the ratio was 1.2 parts to one million parts water, ranged between 12 and 17 cents per capita per year using sodium fluoride. The use of sodium silicofluoride in the future is expected to reduce the cost to about six cents per capita.

— Ontario Department of Health



# The District Nurse Knows Better

MARGARET KIRK

*Editor's Note:* Miss Kirk is a New Zealander who completed her course in public health nursing at the University of Toronto School of Nursing then joined the staff of the Indian Health Service, being assigned to the Micmac Health Unit at Shubenacadie, N.S. The article below was written primarily to inform the nurses "down under" about the work she is doing in Canada. Hence, there are some descriptive passages that will present a familiar picture to Canadian nurses. But for the thousands who have had no experience in a rural health service, Miss Kirk's quick perception and sparkling sense of humor lighten the day *and* night responsibilities that are inevitable in such work.

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I AM WRITING from an Indian Reservation in central Nova Scotia, that quiet little province clinging to the eastern seaboard of a vast continent. True, the visitor seeking the rustic simplicity described on his tourist pamphlet believes it peaceful. The district nurse knows better!

This is the largest of more than a dozen such areas set aside for the Micmac Indians, native Canadians of Nova Scotia, "to be neither bought nor sold, nor trodden by foot of white man without permission," although today the latter clause is modified. All around sprawl hills clothed in a forest of conifers, well mixed with eastern hardwoods, maple, birch and oak. In clearings, which have been given over to the wild blueberries, cluster the homes of the Micmacs, statistically a dying race but, with intermarriage, really suffering from white absorption. Some squares of green indicate potato patches, but the hard stony land does not respond well to cultivation, nor its masters to the thought of labor!

During the summer these families, from grandpa to the newborn, forsake their own patches and head for Maine where, at the height of the commercial potato and blueberry harvest, good money is to be had. However, the majority find it necessary to "hitch

home," often spending a night unconcernedly in a county jail.

The fall (and what a sight are those blazing scarlet maples!) calls hunters to don regulation red caps and leave for the woods. Many Indians proudly wear the badge of licensed guides, and wait to conduct excited American businessmen to their first deer. Now with the first dusting of snow they are cutting and hauling Christmas trees out of the forest on homemade sleds; fir and prized blue spruce, which will give joy to city homes.

All winter they will watch traps, dreaming of large beaver and muskrat pelts, as they snowshoe hopefully over their traplines. Beaver is rare now, and the trapping season limited for their valuable pelts, but there is a bounty on the little sniffing nose of Mr. Muskrat.

Indoors, a cottage industry flourishes. While husbands split maple and birch saplings to unbelievable thinness, wives weave baskets of every shape, size and color. Others use the wood shavings to make exquisite flowers and sell them in the Halifax open market.

The Health Centre (for such my residence with clinic and dispensary attached is called) emerges sturdily above the surface of a hilltop.

Howling Atlantic gales bring rain and fog and, as the season progresses, sleet and blizzards whistle by all the way from Hudson Bay. It requires increasing strength to open a front door directly facing the west, and even more to shut it again.

In our community, pride of possession is a foreign expression. The Indian homes, little two-storied boxes of shingles and shakes, are barely furnished. As always some are spotless, many terribly overcrowded, and others uninhabitable yet inhabited. To you in a land of bungalows it must be explained that the square high house, however unbeautiful, heats better through a long winter, specially when cooking is on a wood stove also used for heating. Water is carried

from common wells. I try not to imagine the washing facilities, nor notice the consternation when nurse wants to wash her hands. However, as a teaching measure the ritual is carried out, in a grubby basin if necessary. Whether I end up any cleaner or not is beside the point.

For my sake interviews are held in English, though all family backchat continues in Micmac. Today, few can read and fewer write this language that the French Jesuit priests so patiently transcribed into Arabic symbols, with the first telling of the Gospel in Canada's history. The original Indian hieroglyphics are preserved in an old prayer book belonging to the parish priest, and with a little imagination they can be guessed at. The sign for marriage is a primitive but obvious double bed.

To describe the actual duties of a nurse in the Indian Health Service, only the word "generalized" would ever qualify. Newly postgraduated and fresh in the field of public health, I was bent on the education of my public, and they on the education of the nurse. Initiation included meeting the Government agent, who generally administers public affairs and finances within Indian territory, and afternoon tea with the chief. I asked about a plan of work. "We haven't any. You must make your own," they replied.

For the first few mornings I was besieged with ailments of every description. After suturing some lacerations, writing an obesity diet for a 300-pound brave, and generally diagnosing and prescribing with the license of a family physician, I thankfully referred the doubtful cases to the doctor who called once a week. When everyone had satisfied his curiosity regarding the new nurse, callers slackened off, and the plan was able to organize itself.

In this area, where the weather conditions play a decisive part in one's program, much of the routine work must be fitted into the late spring and fall, as after the middle of November, no guarantee of arriving on schedule can be given. Some of the roads have a Burma-type surface — a giant washboard, camouflaged ditches, and every corner a right angle. It is, indeed, a far cry from the super high-

ways of Ontario. I roar around the wilderness in a mud-spattered Pontiac, stones flying, dogs barking. I carry enough pills and potions for a mobile drug store, a large black bag labelled "general," and another labelled "maternity." Several times my trusty vehicle has allowed itself to get stuck, but we have always been rescued by a crowd of yelling little Redskins, crying "The nurse is in the ditch up to her fender," and regarding it as the event of the week.

Once, when bearing a supervisor from headquarters in Halifax along a narrow track, we found a rock submerged in a blackberry bush and smashed a door. A small boy, our only witness, said comfortingly, "Yo' sho' was going a pace, missus."

With headquarters at the largest settlement, the smaller communities, some of them 150 miles distant, look forward to regular visits from the nurse's car, bringing "needles," books, cod liver oil, cough mixture, headlice lotion and goodwill. The school children eagerly help to unload baby scales and the movie projector with collapsible screen. They are as awkward in a car as a pair of skis but our latest pieces of equipment so are held in deep respect. Incidentally, during the late fall months it is a wise measure always to carry a sleeping bag on journeys which involve a night away from home.

At one school, rather isolated from white contact, the beginners are learning their first English. When the nurse appears even the smallest rises and bows. The next move is from a boy who says, memory-style, "May I take your coat, ma'am?" and carries it reverently to the cupboard. Even if icicles were forming on my nose, to keep it on would be the end! Another brings a tin basin of warm water, and, under the wondering gaze of big brown eyes, I wash up with dignity. The pupils then display their arms, with precision and confidence, to receive their "boosters" of triple vaccine (diphtheria, pertussis, tetanus). There is only one room in which to do everything, yet the children give perfect cooperation. The older ones all can tell why these are necessary.

The fathers had to be rounded up to mend baby-carriages and carrying



baskets before the first few mothers toiled to baby clinic. Alas for the beautiful literature I had seen on display during our course! Not very suitable for showing a mother with two bottles and a black pot how to prepare formula! How often it is necessary to modify our preconceived ideas of hygiene to conform to local standards.

I remember a father who proudly presented a pickle jar containing the roundworm three feet long, which my pills caused to escape from his daughter. "Very good pills, miss; better than Indian medicine."

There was the time when everyone seemed to complain of sore eyes. It was baffling till I discovered the first T.V. set, standing gloriously alone in a home with little else visible. Each night as many as would fit sat on the bare floor till the end of the program, well after midnight — and were thoughtfully charged 25 cents by the owners!

Then came the x-ray survey, when crowds flocked round the portable generator and equipment set up in church, school, or home, but could not find the courage to try it. Some hid in attics and others fled to the woods. Tuberculosis among Indians and Eskimos, as with other native races, finds little resistance and is difficult to control, despite frequent surveys of everyone over six months old, and B.C.G. for the infants of parents who can be persuaded to give consent. All preventive measures, taken for granted in so many communities, must be fought for patiently and persuasively, yet when an Indian is sick there is no one with greater faith in a needle. Rather than encourage him, it is often more a matter of discouraging the prescription the Indian has set his heart on.

Indian days are measured from dawn till dark, and I have never seen so many unpunctual pupils at any school. "Off duty" means nothing either. However, when a person has

walked two miles down an icy, pitch-dark road, it is difficult to refuse him no matter how trivial his complaint may be. The arrival of babies excepted, the most exciting things usually happen at night.

There was the early rising toddler who, with his puppy, ate two packets of chocolate laxative (about 20 times the dose). It was a minor disaster for the boy, but his dog was missing for days!

On the night of the first snow-storm this year a lone drunk man almost beat my door down. With all the Christian love I could muster I beamed "Come in" and he did, with a cloud of flakes, and his muddy snow-caked boots right on the mat. "Wife drinking," he muttered. "Threw pot of tea at my boy and ran away." I donned winter uniform (ski pants) over pajamas, and with chains rattling we slithered through 40 miles of slush taking a burned, scared nine-year-old to hospital.

After a beating a mother plodded up one night to say she was so discouraged she was going to leave her ten children. After pouring out her woes she was persuaded to return, so back we plodded to find husband snoring and the doors locked. Like common thieves we quietly pried open a window and I pushed her in.

Legislation forbids the sale of liquor to an Indian, so thrives "bootlegging," and home brewing with yeast cake from the grocery store, or aspirins saved up from nursing station distributions. All the misery and degradation associated with it follows.

Life in this manner, here pictured so briefly, is likely to continue seven days a week unless the nurse leaves. She did last Sunday and what happened? I was caught by one of those storms mentioned above so instead of being snowed *in* I was snowed *out* and spent the night with hospital friends (no sleeping bag) until such time as the roads were ploughed clear.

Why some human wounds fail to heal may be partially explained by the presence of mucoproteins which agglutinate the patient's own erythrocytes. This may cause "plugging" of the capillaries and produce an inflammatory condition of tissue cells. Although more extensive trials are necessary

to confirm present findings, investigators have discovered that chlorophyll derivatives tend to counteract this condition. Chlorophyll derivative ointment used in the treatment of previously resistant varicose or decubitus ulcers has shown beneficial healing effects.



# Psychiatric Nursing

ELIZABETH BREGG, B.Sc.

IT HAS ALWAYS seemed to me that the definition of terms, while of great importance in any interchange of ideas, can be a tedious and rather frustrating use of time. This is especially true when one is considering nursing because everyone has a definition of nursing. It is always a definition garnered from the individual's own experience, the experience of his friends, impressions of Sairy Gamp and Florence Nightingale and the disingenuous stories from Hollywood. It is always peculiarly his own and subject to all the bias and prejudice of his pattern of living. This makes many people quite ready to speak of and for nursing. There is no other discipline, unless perhaps it is psychology, with so many spokesmen, so many critics and so few really informed supporters. Nursing therefore becomes a complicated picture in the minds of our public. As soon as we add to the muddle the adjective "psychiatric" we are launched on a very rough trip indeed. Here we really come face to face with feelings, fears, suspicions, and a rather horrified fascination. Many in and out of medicine and nursing have the comforting idea that if we don't talk too much about it, it may go away. Sometimes the more anxious relieve their feelings by reflecting that while it is interesting, nurses and doctors who stay too long in psychiatry get a little queer too. In some way this relieves the discomfort.

Whatever the method of arrival employed, most people reach a definition of psychiatric nursing. This will most certainly be one best suited to their particular feelings in this area. Because of this, the majority must think of psychiatric nursing as the kind of nursing carried out in mental hospitals in the midst of hopelessness, disturbance, premeditated homicidal attacks, noise and confusion. They are upset to think of "nice" young girls exposed

to these sights and sounds. These misconceptions and anxieties are revealed in countless ways — most obviously perhaps by the apathy which allows us to ignore fairly completely the thousands of our citizens who are confined to mental hospital. So, for many, psychiatric nursing is something carried out in mental hospitals. This is of the greatest concern to me and gives, I believe, a completely erroneous picture of the concept of nursing which is developing today.

A patient is always a member of a social system. Removing him to hospital does nothing to negate this. It complicates simply by the addition of a new pattern of living and feeling. It accentuates his interpersonal difficulties, creates new social problems and removes tried and trusted props. The most adequate of us responds to this strain with more or less anxiety, irritability or the pronounced use of other defence patterns. The nurse receives the full impact of this and responds. If she responds with perceptiveness, sensitivity and warmth to unspoken needs, she guides the patient towards physical and emotional comfort. She is also practicing psychiatric nursing which is the refinement and most skilled use of the interpersonal situation for growth and health.

Psychiatric nursing becomes, then, the skilled use of the nurse-patient relationship to aid the patient's recovery, to help him handle difficulties as they appear to him, to meet needs unmet in the past and to restore him emotionally and physically well to the community. There is no successful nurse practicing who does not in some way attempt this. Her degree of satisfaction depends on her ability to operate in this way. It is an essential if she is to gain satisfaction because, for an intelligent woman, the routine of physical care divorced from this wider area is not stimulating. Only to the very young novice in nursing can the making of a hospital bed give a glow of achievement that will last all day. It is in the attempt to under-

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stand the complex person in the bed and the equally complex person in the uniform that satisfaction, challenge and development occur.

Many of our student nurses in Ontario are now offered a 12-week experience in nursing the mentally ill. There are many rather confused reasons for this but basically, I think, it is a recognition of the interdependence of mind and body and the hope that somebody somewhere can teach this in 12 weeks. Some centres now complacently plan to do it in eight weeks — a completely unrealistic point of view since time as a maturation factor cannot be overlooked. Whatever the motives, psychiatric nursing has become a 12-week specialty and there it stays. A student nurse may reach this at the end of her first year of practice or at the end of her third year, or, due to force of circumstances, she may never reach it at all. This in spite of the fact that from her first hour on the ward she is dealing with emotional disturbance of greater or lesser degree in herself, her patients and her fellow workers.

I think there was a time when the lot of the nurse was simpler than it is today. She simply worked under direction. Her task was "to carry out" rather than "think through." To some this business of "carrying out" is still the highly desired characteristic of the nurse. There is much distrust of higher education for nurses especially if this education removes the student from the confines of the wards. In those situations where a nurse is still expected to "carry out" and not "question through" her task is simpler but the turnover of staff is enormous. When encouraged to think through, she becomes often a storm centre and the tides of resistance grow. Other things grow too — independence of thought, greater respect for the knowledge of others and a healthier climate for patients.

Now psychiatric nursing when it is locked in a mental hospital and custodially oriented, is as dead as nursing in a general hospital when shackled by blind routine and militaristic hierarchy. Nursing is a function — one of the functions of the health team. The operations of nursing are technical and interpersonal. Almost anyone of nor-

mal intelligence can learn most of the technical aspects of nursing but only a nurse specially educated to recognize and respond to the patient's need for help can go beyond the routine and supply relief or the means of future growth. And it is this going beyond that has come, in many instances, to be called quite erroneously psychiatric nursing. It is this misconception which restrains nursing from fulfilling its highest calling. What saves us from complete failure is the fact that the ranks of nursing are filled with women who have the vision and maturity to go the extra half-mile and to take the young nurse with them. Unfortunately, many who do this complete nursing have never thought through their methods or the reasons for their successes and failures. Therefore, they cannot teach it — the learner has to be exposed and catch it. Some people have a natural immunity.

If we accept the desirability of this complete nursing then we can use our experience and knowledge to put this so-called psychiatric nursing back where it belongs at the root of nursing. This does not mean that skill and knowledge in technical areas will ever decrease in importance. On the contrary, techniques will become of greater use and value, will be the exordium to a fuller relationship with the patient and a greater acceptance on his part of the help offered.

This leaves us still with the responsibility for hundreds of acutely ill psychotic and neurotic patients. What kind of nursing do they need? The answer is no different. They need the same perceptiveness, sensitivity and knowledge that is due any patient. The difference is in the degree of these qualities and in the stability and maturity of those nurses who choose to work with the mentally ill. It is not a new or different kind of nursing but rather a refinement of nursing where challenges are great and satisfaction tremendous.

We shall never achieve this kind of nursing as long as our emphasis is on techniques but we could come much closer were we to put what we now call psychiatric nursing out of the specialty area and back to the beginning of our nursing education programs. Then we could really use the



special 12 weeks for intensive development and growth for the student and the mentally ill patient.

This, it seems to me, is the real challenge of nursing as it is for medicine and hospital administration. Nothing will go smoothly until our teaching

helps us to work with people — starting, if you like, from the patient and spreading out in all directions. It is a terribly difficult assignment because it always involves oneself and this, as most of us know, is a subject which, like psychiatric nursing, is fascinating but not quite healthy.

## Fun on Trains

MARGARET STEED

**A**LL ABOARD! Is there anyone who has not thrilled to the exciting possibilities of those words? The shrill warning of the whistle as the train nears the crossing, the roar of wheels, the rush of escaping steam as the cars slide to a stop, the sense of adventure and anticipation hovering over the waiting passengers — all arouse an eager longing to climb on board and go — somewhere, anywhere.

As a child in a small railroad town, I used to watch the west-bound train as it pulled away from the station and picture where it went. I could see it nosing its way through the dense bushland of Northern Ontario, rocking round the curves of the beautiful north shore of Lake Superior, then, on across the prairies, golden with wheat, until the rolling foothills introduced the Rockies. Here my imagination failed me! I knew the Rockies were big — bigger than the “mountain” down which I slid on my toboggan in winter. I know now that they must be seen to appreciate their vast grandeur.

I had a dream. Someday I would be one of the lucky ones to whom the conductor would shout his invitation. Someday I, too, would see those wonderful, faraway places.

That dream became a reality when the CNA biennial convention was held in Banff. The click of the wheels on the rails became a song in my mind:

Nurses, nurses I've been thinking  
What a dull world this would be  
If we never had conventions  
Taking us from sea to sea.

Miss Steed is an ardent travel enthusiast from Toronto Western Hospital.

The fun started as we met more excited, happy folk like ourselves scurrying through the crowded terminal. For many it was to be their first experience of living and sleeping on a train — an adventure in itself. Each coach had a captain who acted as hostess and human encyclopedia. The questions! Passenger lists were provided which smoothed out the scramble to find the friends you *knew* were there and surprised you with the names of some whom you had not expected.

Each day was packed to the brim with activity. Commercial well-wishers contributed fresh variety daily — a fragrant rose delighted each of us one morning. The larger gifts were used to prove conclusively that the gambling instinct is equally strong in both sexes. Every night one of our number gleamed with the luck of the Irish. In the evening the parlor car resounded with our enthusiastic singing.

And then there was the day of the hat-fashioning contest! It's amazing what one can do with a coat hanger, a powder puff, a cake carton, a jar of pickles or olives, soda crackers and countless other bits and bobs. They were not only wearable — some fashion-conscious souls modelled them at the next station stop — but were also, in some instances, edible.

The entire trip took on the atmosphere of a triumphal tour as we were met at one local stop by a bag-pipe band, serenaded at another, waved hello and good-bye at still others. It added that extra bit of zest to the general feeling of good will, good humor and adventure which pervaded the whole train.



And now another convention year is upon us. Our hardworking convention coordinator is already far advanced with her arrangements for you, planning your trip in the same excel-

lent fashion as before. So make your reservations early, don't forget to bring your sense of humor and spirit of adventure and let's climb on board the Funland Special to Winnipeg.

## ALL aboard!

# THE NURSES' ROLE IN CIVIL DEFENCE

**A**N INSTITUTE ENTITLED "The Nurses' Role in Civil Disaster," the first of its kind to be held at the Saskatchewan Civil Defence School since its inception in 1951, was recently concluded.

This institute was sponsored under the joint auspices of the provincial civil defence organization and the S.R.N.A. It was held at Valley Centre, Fort Qu'Appelle, which is the training centre for civil defence activities. From the comments made by those attending the institute, it appeared to be generally agreed that the benefits derived from attendance at the institute greatly offset the lack of seasonable enjoyment. Many Saskatchewan nurses had previously enjoyed the privilege of attending the course on ABC warfare conducted by a team from Ottawa in December, 1951. Many others had been trained over the years at courses given locally. This was the first course conducted at the provincial level since 1951.

A real need had been felt for a refresher course for some and an indoctrination program for others. It was with this thought in mind that the program was planned. Nurses from various localities in the province were invited to attend. They represented schools of nursing, public health nursing and institutional nursing. The response was very gratifying.

There were 47 nurses enrolled for the complete course. The speakers included nurses who had recently attended the Civil Defence College, Arnprior. The material that they presented was practical and interesting as well as instructive. Miss Evelyn Pepper, Nursing Consultant of the Civil Defence Health Services, Department of National Health and Welfare, attended the institute and contributed vitally to the worth of the program. The success of this institute has provided a real incentive for further gatherings along similar lines.



*Civil Defence School in Saskatchewan*

# NURSING EDUCATION

## Nurses as Teachers of Science

ALMA E. REID, B.A.

### *The Story of How One Canadian University School of Nursing Commenced Something New and Different in Nursing Education*

A SIGNIFICANT DEVELOPMENT in professional education of the past thirty-five years has been the place that nursing has found, or probably more accurately, is finding as one of the professional disciplines in Canadian universities. The early beginnings and subsequent course of this development in each of the universities across Canada would make an interesting study. For the most part it has varied according to the particular demands of nurses and nursing in the locality, the resources of the university (which means financial as well as other resources) and most of all, according to the philosophy of education and predilections of those who pioneered in and promoted the development. A study of this development in all its variations, while revealing much individuality and dissimilarity in the many programs, would likely show common characteristics and grounds from which might be deduced guiding principles for nursing education in universities. Here is the story of how one program, specially designed for professional preparation in nursing, was conceived and planned in one Canadian university.

It was from a conviction that the university school of nursing has a real responsibility to serve the demands and needs of nursing that the Mc-

Master University School of Nursing decided to enter the field of post-basic nursing education. Since 1942 McMaster has conducted a program in basic nursing education, a program which, having emerged from the inevitable vicissitudes of all early developments, has now become well-established as a four-year degree course. Hence, the time seemed propitious to extend the offerings of the university to graduate nurses. Innumerable requests from graduate nurses concerning the possibility of study at McMaster made us increasingly aware of the university's responsibility to aid in furthering the betterment of nursing education in some way other than by a degree course in basic nursing. The interest of the W. K. Kellogg Foundation in giving financial assistance for the initial period of an approved project served also to make us think more seriously on the question.

In considering the type of contribution which the University might make to nursing, several questions came to mind, questions which needed to be answered before conclusions necessary for the formulation of specific plans could be made:

(1) In Canada today, what particular field or fields of nursing education are being neglected, or, are at least poorly provided for either through university programs or other means? From the outset it was agreed that if our objective truly was to assist post-basic nursing education, then we should not duplicate

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Miss Reid is the director of the School of Nursing of McMaster University, Hamilton, Ont.



courses which neighboring universities are already offering, since at the present time these courses are not over-enrolled. At the same time, it was essential to ascertain in some way that there would be sufficient numbers of graduate nurses in Canada interested in the type of preparation offered, in order to warrant our university setting up such a course. The blessing and support of the organized profession for whatever was undertaken must also be assured.

(2) Has McMaster University adequate and satisfactory facilities, including personnel, to undertake this work and has the project full understanding and acceptance in the various administrative and academic bodies of the university, were vital questions.

For obvious practical reasons it was necessary to settle upon some field of nursing education before commencing any inquiry which would enable us to explore the aforementioned questions satisfactorily. Preparation for the teaching of basic sciences in nursing was the field upon which we chose to centre our attention. Our reasons for making this choice can be attributed partly to our knowledge of the existing weaknesses in science instruction in schools of nursing which we believed was due, in some measure, to the inadequacies of those giving the instruction, partly to our awareness of the tendency for Canadian nurses interested in this field to enrol in courses in the universities of the United States where special science preparation in nursing could be secured, and partly to our own experience in and facilities for teaching basic sciences in nursing at McMaster.

Along with our exploratory study went course planning, for in the process of soliciting opinions and ideas on the present situation and need in science teaching, it was natural that we could also secure some help towards formulating a course of study. Both processes involved much time, to say nothing of effort. The whole story might make rather tedious reading, if related in all its ramifications. For us it was fascinating and interesting, even though long drawn out and discouraging at times.

Suffice to say, the preliminary investigations and plans were carried out in a variety of ways: discussing the

matter with leaders in nursing education in Ontario and with persons who are recognized authorities in this field in selected centres of the United States; soliciting opinion and data by means of questionnaires sent to 60 hospital schools of nursing in Ontario, 35 representative hospital schools throughout the other provinces of Canada, and 12 schools or departments of nursing in Canadian universities; sponsoring a workshop for graduate nurses on the topic "helping students use science in nursing"; conferring with the members of the executive of the Registered Nurses' Association of Ontario (two of whom were also members of the executive of the Canadian Nurses' Association), representatives from the Nursing Branch of the Ontario Department of Health, and with members of the administrative and academic councils of the university.

While complete unanimity of opinion on all points was not expected from the many individuals and organizations consulted, it was helpful and interesting that there was sufficient majority agreement on certain fundamental points to enable us to proceed with plans in a spirit of good confidence. The pertinent findings, elicited through the measures undertaken, might be briefly summarized.

There was fairly universal agreement that the teaching of basic sciences in schools of nursing presents problems, and that there is dissatisfaction with the results of the present methods and means of teaching these sciences. A conglomerate group of people is today teaching these subjects: nurses holding degrees of one kind or another, nurses holding special certificates for teaching, nurses without special qualifications, doctors, high school teachers, pharmacists, dietitians.

Most schools said that they were not in a position to purchase science teaching for their students from a university, college or high school, and many of those who are now purchasing some of this teaching, or have done so in the past, expressed dissatisfaction with it due to cost, loss of student time, inappropriate teaching, etc. Practically all schools, excepting those participating in the centralized program in Saskatchewan, employ one and



sometimes two so-called science instructors.

There seemed to be a definite preference for nurses as teachers of science as opposed to any other persons or arrangements, yet there was almost general agreement that a definite lack of well-prepared teachers of sciences in schools of nursing exists in Canada. The reasons for this were not sought, but we all know too well that they are not due entirely to a lack of available preparatory training for those wishing to enter this field. Economic and other security factors of employment, on top of a proper regard for the position of the science instructor, play an important part in this sombre situation.

As a solution to some of the problems of science teaching in Ontario, the idea of a central school for certain instruction, including science instruction, was considered. It was thought that this might be practicable in some regions but could not be recommended as a general solution to the problem, partly because of the geographical isolation of a goodly number of schools and partly because of the large student enrolment in about ten hospital schools for which good facilities have been set up.

The need for a specially designed course to prepare science instructors in Canada received strong support from a large majority of those consulted. One or two interesting questions were raised in opposition to the question of whether such a course were a prime need. What constitutes basic nursing science and what do students in nursing need in the way of science, were considered by one or two thoughtful persons to be more fundamental and pressing questions. In consideration of these undoubtedly pertinent and sound questions, we agreed that they were important queries and ones which we are still far from answering to the satisfaction of all. Yet could it not be through such a program as was proposed that such questions could be studied at least academically, and steps initiated for some experimental work in solving them? Without being unduly pessimistic, there seemed to be little hope in our present situation that such big

questions could be even tackled, let alone solved.

As has been mentioned, help was also gained with respect to planning the course and its content. Early in our considerations, we saw the wisdom of planning a degree program, rather than one leading to a certificate. To establish a certificate program seemed to be, at best, only meeting the present emergency, and not encouraging or providing for an acceptable preparation for science teaching. The suggestion that the certificate might be the first step to a degree had merit, but the idea was abandoned as the difficulty of arranging a desirable sequence of studies made it impracticable, and pedagogically speaking unsound.

Whether the biological sciences should be studied as an integrated whole, rather than separately, was another interesting question. Here our decision was to study each science individually, for it was our belief that the person preparing to teach sciences should, first and foremost, possess a sound knowledge of the individual sciences, since, from this vantage, integration would be definitely safer and easier. Provision could be made for some assistance in the principles of integration in seminar discussions.

Probably the longest delayed deliberations occurred at the University, where the project received sympathetic and keen interest but *very* careful scrutiny. Universities tread cautiously on new ground these days! Ours explored it for about two years. Some of the delay, however, could be explained by the longseeming vacuum which occurs at a university between spring convocation and registration in the fall. This project came to the "powers that-be" just at the commencement of that period. Before presenting the plans to the Board and Senate of the University, the curriculum of the course had been framed. The final outcome of the Senate's consideration of the project was the appointment of a special committee to study the matter in detail and to make recommendations. This committee had as its chairman a professor of physics. Three other Senate members and the Director of the School of Nursing made up the committee. It worked hard through many long, interesting,

but difficult meetings. Differences of opinion and outlook had to be reconciled and compromises reached. Frequently, expert help from other faculty members was sought. The committee concerned itself chiefly with curriculum content, and at the outset agreed upon certain criteria as guide-posts in the study:

That the program should be at least the academic equivalent of the "Pass" B.A. degree;

that subject content should centre on fundamental learning rather than applications;

that, as far as possible, the curriculum should be planned around existing courses in the university;

that non-science subjects and electives should form an important part of the curriculum;

that, for self-evident reasons, the course should embrace as short a period as possible.

The curriculum recommended by the committee of the Senate was eventually presented to the curriculum policy committee of the University and approved. From here it came under fire at a full meeting of the faculty, where, after an interesting and memorable discussion, lasting about one hour, it was accepted with a few minor adjustments. Subsequently, the Board and Senate gave the course their endorsement, and we were away, at least, that is, so far as the University was concerned! The W. K. Kellogg Foundation, having waited patiently and interestedly throughout our investigations and deliberations, confirmed its willingness to accept the proposed project for their support over a maximum period of five years. The scramble which ensued in publicizing the course among interested nurses and in preparing for the commencement of the course, speaking mildly, resembled wedding haste! This phase of the development would be shared gladly with any interested persons, but does not seem to warrant telling here.

To conclude this story without telling you a bit about the course would be something like telling you how to make a cake, but saying nothing about what is in it or how it looks or tastes. Since we are rather proud of our "cake," and think it should "taste"

good to nurses, we want the nurses across Canada to know something about it.

Entrants to the course must have complete senior matriculation standing including mathematics, physics and chemistry. This is essential because the studies of the course begin from this background. The course, as outlined, extends over a period of two academic years with additional requirements which may be taken in the intervening and following summer periods. If circumstances make it impossible for students to continue for two consecutive years, it is possible, if a degree is to be granted, to take the course over a longer period, provided the requirements are met within five years of the date of enrolment. Much of the liberal arts and other requirements of the course may be obtained in another approved university, and through transfer of official credits would be accepted by McMaster. Conceivably some might obtain these credits while in employment by enrolling in extension studies offered by a university. The provision of some flexibility in the course seemed desirable, especially as graduate nurses have already devoted three years to their professional preparation and are often confronted with problems of finance and personal responsibility.

The studies of the course include a combination of social, biological and physical sciences, humanities, nursing education, and theory and practice pertaining to the teaching of sciences in schools of nursing. The curriculum totals 107 units of credit as compared to the "Pass" B.A. degree requirement of 102 units. It is of interest to note the relative proportions of the main branches of study:

Physical and biological sciences occupy 44 per cent of the total unit value of the course; liberal arts, including social sciences, 30 per cent, and professional studies the remaining 26 per cent. Ten units of credit are allowed for the basic course in nursing and make up a part of the 26 per cent of the curriculum devoted to professional studies. While the program is designed specially to prepare graduate nurses to teach basic sciences in schools of nursing, it also provides a good background of prepara-



tion for teaching in any field of nursing. General scientific principles and teaching methods are incorporated in the course.

One interesting and rather amusing sidelight occurred when the question of the degree to be conferred was being discussed in one of the academic councils of the University. The recommendation that came to this council was that the degree would be Bachelor of Education in Nursing (B. Ed.N.) and that the academic hood would be of certain colors and would be unlined, on the grounds that this was a secondary degree. Immediately the chairman of the special Senate committee rose to his feet and protested. In no uncertain terms, he gave facts which showed that the course merited no second-rate degree. He was ably supported by other members of the committee, and, as a result, the lining will

be included in the hood!

This is the story, so far, of our venture into the field of post-basic nursing education, a venture that has been born of much cooperative planning and for which we are indebted to many people. We trust that in time it will prove, as other post-basic nursing courses in universities have already proven, of sound worth to professional nursing. We trust also that it strikes at the roots of some of the real problems in science teaching in schools of nursing. We have striven, in planning for it, to take cognizance of some of the fundamental demands of Canadian nursing both from the standpoint of general education and professional preparation. In other words, this course has been conceived from the needs and for the good of Canadian nurses.

## An Orderly Training Program

MARY L. RICHMOND, B.N.

**I**N VIEW OF SOME PUBLISHED differences of opinion about the value of an orderly training program, and to help dispel what appears to be a negative or pessimistic attitude toward such a program, we would like to report what we feel was a very worthwhile undertaking in this field.

There is, basically, only one reason for establishing any training program within the hospital — better patient care. The other reasons — better utilization of personnel, clearer definition of duties, greater job satisfaction, increased loyalty, more tolerant interpersonal relations — all may be real and significant outcomes, but constitute justification of the time, effort and expense, only in so far as they contribute to better care of the patient.

That an orderly training program was needed in our hospital was indicated by: high rate of turnover of orderly staff; general low morale among the group; a lack of integration

with the total nursing plan; a lack of uniformity of opinion among orderlies and nurses as to their rightful duties; and a rather general feeling among the orderlies that they were being "put-upon," and among the nurses that the orderlies did not always carry a fair share of the nursing load.

While these had constituted a need for action for some time, the immediate impetus to set up a training program came from an administrative interne, who, throughout the program, assisted with the planning and correlating. It was felt that any program of training in patient care should be intimately linked with the school of nursing, so the educational director and the nursing arts instructor were brought into the plan at its beginning. These, with the administrative interne, the charge orderly, and selected head nurses, constituted the planning committee.

Since before a training program is established one should "set objectives," initial discussions were held with the head nurses as to what the orderlies should be expected to do. These discussions revealed very widely diver-

Miss Richmond, who is educational director at Royal Jubilee Hospital, Victoria, is currently taking some further postgraduate study.



Should he be in charge of an orderly in a mental hospital? Should he be in charge of a porter? Should he care for the elderly patients? Should he be in charge of a task force? Should he be in charge of dressing? Who

of an aide on a woman's ward?

Such discussion revealed our great need for a job description — at least an informal, if not a highly organized one.

After reasonable agreement on such points, an outline was prepared of the procedures that orderlies might be taught. These formed a core around which a series of classes in ethics, basic sciences, and nursing arts were planned. Throughout, emphasis was placed on the orderly's role as an essential part of the nursing team. As far as possible, the nurses' "nursing procedures" were taught, the same mimeographed outlines being used as for student nurses.

The classes in ethics were given by the medical administrator and the administrative assistant; those in basic sciences by doctors and the instructors from the school of nursing, and those in nursing arts by the senior nursing arts instructor. Provision was made for supervised practice, and for both practical and written examinations.

## Intolerant Mothers

A new theory of the basic cause of eclampsia has been proposed. According to the new concept, fetal hormones can and do pass through the placenta in increasing amounts during pregnancy. These hormones, particularly the fetal insulin and sex hormones, are not always welcomed by the mother. Her tolerance varies with the carbohydrate content of her diet. When the mother's tolerance reaches its limit a reaction occurs which shuts off the entry of the hormones by damaging the syncytium, the outermost layer of the placenta.

The damage to the syncytium impedes nutrition of the fetus and often kills it (fetal mortality in eclampsia averages 35%). The damaged syncytium also produces poisons. If pumped back into the maternal

circulation by the fetal heartbeat or uterine contractions, they cause a toxic condition and precipitate eclampsia in the mother. Eclampsia is the most frequent cause of maternal deaths in many parts of the world.

The certificates were presented at a luncheon attended by the orderlies, the director of nurses, the hospital administrator and his assistants.

The program has now been presented twice. In the first series, twelve men completed the course, in the second, four men. It is planned to repeat the course as necessitated by changes in the orderly staff.

We believe the orderly program has been worthwhile. The initial planning revealed the great need to interpret the role of all auxiliary personnel, not only to the individual himself, but to the head nurses and other members of the nursing staff. For the orderlies, the course seems to have resulted in: (a) better acceptance of supervision from nursing; (b) wider participation in patient care; (c) more careful technique; (d) improved nurse-orderly relationships, and (e) less turnover of staff.

We like our orderly training program. We hope to reconsider, revise, and re-present it.

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Geriatric patients, underweight infants and children who suffer from poor appetites may be in need of more adequate supplies of lysine. Lysine is needed by the body for growth and tissue repair. Most infant foods, with the possible exception of meat products, fall short of the body requirements of this substance. The elderly person, too, may not be assimilating adequate amounts of lysine from his diet to supply body needs.

— Lederle Laboratories

# NURSING SERVICE

## Meconium Ileus

DORIS WRIGHT and JOYCE BULLOCK

**T**WIN BOYS WERE DELIVERED at the Royal Victoria Montreal Maternity Hospital on August 31, 1955. The first-born, Alex, was the larger, weighing approximately five pounds, while Bobby weighed just over three pounds. This was the fifth pregnancy for their mother and the birth was difficult for both babies. Alex's respirations were poor and he required resuscitation measures immediately following birth. Bobby was a breech presentation and he, too, showed respiratory distress and required oxygen upon delivery. Both babies remained in the case room for some time before they could be taken to the premature nursery and even then Alex's color was slightly cyanotic and he required frequent suctioning to remove a collection of thick, green mucus.

Bobby showed no apparent abnormalities upon physical examination following birth but approximately eight hours later his abdomen was distended and before his initial feeding at 4:00 p.m. of that day he had begun to vomit bile-colored liquid. Alex developed similar symptoms just a few hours later. Dark green fluid was aspirated from his stomach. He was unhappy, crying almost constantly and unable to retain his first feeding of glucose and saline although he was only given two ounces. Bobby did not retain his feeding either.

The following day neither babe showed any improvement — Alex's distention had, indeed, become worse. Ordinarily a newborn babe passes a meconium stool within 24 hours.

Miss Wright is the clinical instructor and Miss Bullock, the head nurse, of the pediatric ward, Royal Victoria Hospital, Montreal.

Bobby passed a small amount of hardened meconium but Alex did not have any movement. A rectal examination was made on Alex and no evidence of meconium was found, suggesting a definite abnormality. As a result both babes had abdominal x-rays taken. The subsequent radiology report for Alex was as follows:

The radiological characteristics of the intra-abdominal contents of this baby showed marked dilation of the proximal small bowel loops due presumably to a complete bowel obstruction somewhere in the proximal jejunum. The presence of calcium on the right side of the abdomen pretty well establishes this as an example of meconium peritonitis.

Bobby's x-ray gave the appearance of an "acute small bowel obstruction," possibly somewhere in the jejunum. The appearance of the remainder of the abdominal contents was, as in Alex's case, suggestive of meconium ileus. Surgical intervention was clearly indicated and both boys were transferred to the pediatric ward for pre-operative preparation.

Everyone on the pediatric ward had been alerted and orientated regarding the coming of the twins and their subsequent care. The condition was unusual, the babes in a critical state and intelligent nursing care was a major necessity. Alex and Bobby were placed on special frames to immobilize their arms and legs and provide good abdominal exposure. Venous "cut-downs" were performed on both babes and 5% glucose and water administered. Alex went to the operating room at 4:00 p.m. on September 1 and Bobby followed at 6:45 p.m.

At operation Alex was found to have a large loop of greenish colored, completely necrotic, matted bowel.



There were numerous fleshy, vascular adhesions and a dilated proximal loop. The necrotic area was excised and the two lengths of small bowel were brought into position and sutured to the peritoneum. Catheters were placed in both loops and Alex returned to the ward in fairly good condition. Bobby was found to have jejunal atresia or narrowing with marked distention of the proximal loop of small intestine and reduction in size of the distal loop. In his case a jejunostomy was performed and catheters inserted into the proximal and distal ends of the jejunum. Bobby withstood the operation well and returned to the ward in very good condition.

Specimens of meconium were sent for analysis from both babes. Significantly, the report indicated an absence of trypsin in both instances and Bobby also had a very low amylase content. The secretion of the mucous glands of the body is thick and viscid. Digestive enzymes are required to liquefy and break down the secretion; otherwise a very thick meconium is produced which the baby cannot expel. This condition is known as *meconium ileus*.

Both babies had pancreatic juice and pepsin introduced into their proximal and distal catheters. Unfortunately, it was suspected that Alex and Bobby were suffering from fibrocystic disease of the pancreas as well — a congenital condition producing characteristic changes in the pancreas and lungs.

Postoperatively the babes were placed in separate humidicribs regulated at a temperature of 90° and humidity 60-70%. In this way they did not require clothing and, therefore, could be observed much more readily — especially as to the rate and character of respiration and color. They were specialised constantly by the student nurses. Continual intravenous therapy was maintained in both small patients — approximately 300 cc. of 5% glucose and water, 25-50 cc. of normal saline and 50 cc. of blood (alternating with plasma q. 2 d.) Oral breast milk feedings supplied by the twins' mother and the hospital Breast Milk Bank were started.

The nursing care was very exacting. The student specials had to observe

their tiny charges carefully and frequently for abnormalities as to color or breathing. Frequent change of position was particularly important since fibrocystic disease is characterized by a tendency to develop pneumonia. Postoperative shock was another complication likely to develop and it was very important to detect the earliest possible symptoms. Pancreatic juice and pepsin were instilled into the proximal and distal catheters q. 2 h. The catheters had to be irrigated q. 4 h. with normal saline. Skin care, particularly around the area of incision where intestinal contents could have caused excoriation, had to be conscientiously carried out. A thick layer of aluminum paste proved most helpful and at no time did infection of the area develop.

The babes followed a demand feeding routine — they were fed whenever they cried. At first this was about every hour then the interval lengthened to every 2-3 hours. Because of their small size, one ounce premature feeding bottles with small soft nipples were used for the babies. The twins managed to retain 10-16 ounces a day. Once the incisions started to heal, the contents of the proximal loop were carefully collected, measured and instilled into the distal loop in both babies. This meant that they could now receive the full benefit of their feedings which, until then, had been largely draining from the proximal catheter. Accordingly it became very necessary that the nurses record accurately all rectal drainage. All intake — intravenous and oral — was noted with equal care. The intravenous injections were checked q. 15 m. and recorded q. 1 h. as to amount absorbed, rate of flow, etc.

Both Alex and Bobby showed encouraging progress for a number of days postoperatively. Bobby passed a moderately large amount of thick black meconium on the fifth day following mineral oil 2 cc. given rectally and through the distal catheter. Thereafter fairly normal meconium bowel movements were established. He developed diarrhea on two occasions but it was well controlled each time. Alex showed much less response to the use of mineral oil, tube irrigation and enemas. However, his abdomen did not become



distended again and he was passing small pieces of meconium per rectum.

On September 10, both Alex and Bobby developed rapid respirations. Alex was wheezing slightly and Bobby had diminished respirations over both bases. X-rays indicated bronchiolitis in the former, emphysema in the latter. Alex received streptomycin 25 mgm. t.i.d. and chloromycetin 100 mgm. t.i.d. while Bobby continued to receive chloromycetin 100 mgm. t.i.d. intramuscularly (ordered prophylactically earlier) and was also given erythromycin 30 mgm. Both babes received an aerosol mixture of alevaire 1 cc., aminophylline  $\frac{1}{2}$  cc. and water  $3\frac{1}{2}$  cc. instilled as a spray into their humidicribs q. 6 h. This helped to liquefy the viscid, tenacious sputum with which they were troubled.

On September 13, both boys underwent x-rays following barium. Alex later passed the barium in his stool and his condition was felt to be improving. Bobby's x-ray showed an essentially normal small bowel. On September 16 he had two normal yellow curdy bowel movements per rectum and the next day went back to the operating room for suture of the intestine and closure of the abdomen. This was not too successful although the two parts of the bowel were brought up to the skin and partially sutured.

Alex's condition unexpectedly deteriorated on September 15. His respirations again became rapid and shallow and the right lung was covered with râles. Streptomycin therapy was instituted. Electrolyte studies, formerly thought to be normal, now showed an imbalance.

<i>Normal</i>	<i>Alex's report</i>
Chlorine 99-107	83.2 M/Eg.
Sodium 138-148	101.8 M/Eg.

At midnight of the same day his condition was critical. Calcium gluconate 5 cc. was added to the intravenous fluid to try to correct the calcium levels. Digitoxin  $\frac{3}{10}$  cc. was given since it was thought that the babe was in cardiac failure. The following day his condition continued to deteriorate slowly in spite of the use of digitoxin  $\frac{3}{10}$  cc. at 7:00 a.m., coramine  $\frac{1}{2}$  cc.

at 10:35 a.m., aminophylline 5 cc. at 3:00 p.m. and a repeat injection of coramine  $\frac{1}{2}$  cc. at 5:00 p.m. Alex died at midnight on September 16.

On September 17, Bobby developed a stomatitis which required the discontinuance of erythromycin. Streptomycin 60 mgm. and procaine penicillin 150,000 units b.i.d. were started. The babe's mouth was treated locally with gentian violet 1% after feedings. Electrolyte studies were done occasionally and always showed a slightly decreased chloride, sodium, potassium and  $\text{CO}_2$  volume. The little boy's condition was good. He was active, feeding well and having yellow and brown curdy stools. On September 25, at midnight, he suddenly became cyanotic with distressed respirations. His extremities were cold and he appeared to be in shock. On examination the doctor found Bobby's lungs clear and his airway patent. Artificial respiration and oxygen failed to help. Adrenal cortical extract 5 cc. administered intravenously at 1:15 a.m. produced no improvement nor did intracardiac adrenalin and he died shortly after.

The loss of the two babes was a source of sorrow to all who had been concerned with their care. Autopsy reports revealed that the prognosis for each little boy was very poor in spite of all medical or nursing care. These reports were as follows:

#### *Alex*

- a) Fibrocystic disease of the pancreas
- b) Jejunal stricture
- c) Obstruction of small bowel
- d) Dilatation and hypertrophy of small bowel
- e) Ascites
- f) Adhesions of mesentery
- g) Acute bronchopneumonia
- h) Hyperanemia and edema of lungs

#### *Bobby*

- a) Fibrocystic disease of the pancreas
- b) Stenosis of ileum
- c) Fibrous adhesions of peritoneal cavity
- d) Dilatation of jejunum
- e) Abscess of abdominal wall adjacent to ileostomy
- f) Atelectasis of lungs
- g) Hemopericardium (4 cc.)

Last year the Canadian Red Cross Blood Transfusion Service provided free clinical Rh tests for 113,110 Canadian women.

# La Société des Infirmières Visiteuses

RENÉE RIVARD

**O**RGANISME D'ORDRE PRIVÉ, la Société des Infirmières Visiteuses maintient un service d'infirmières licenciées, destiné à :

Visiter les malades à domicile.

Prodiguer à ces patients les soins nécessaires en rapport avec leur état et la prescription du médecin traitant.

Faire admettre le malade par la famille, s'il se trouve des rebelles aux situations dépassant l'ordinaire de la routine du foyer.

Faire l'éducation du malade, qu'il n'accapare personne inutilement.

Faire l'éducation des personnes devant s'occuper du malade en l'absence de l'infirmière.

Découvrir les problèmes sociaux s'il a lieu, et diriger le cas aux organisations spécialisées pour le règlement des différents problèmes.

Faire l'enseignement de l'hygiène dans les foyers, au point de vue mental, physique, alimentaire, en tenant compte du budget à disposer et du nombre de personnes à nourrir.

Faire le dépistage de certains malades laissés trop souvent à eux-mêmes, et pouvant être traités.

Puis, animé d'un grand esprit de foi et de charité, semer l'amour, le sourire, le réconfort, la miséricorde, la confiance ou la résignation dans ces foyers fréquemment dénués de toute vie intérieure, de principe, de morale.

## FORMATION DE PERSONNEL

*L'entrevue:* Elle se fait sur rendez-vous, en deux temps.

- Par la directrice: une formule simple d'application est immédiatement remplie par l'infirmière.
- L'infirmière est présentée aux responsables des différents départements du Service.

*Le triage:* Au moment de retenir les services d'une nouvelle infirmière, une commission (formée des responsables des départements) étudie l'application de chaque sujet et fait un choix A, B,

C, en tenant compte aussi d'une priorité, suivant la date d'application.

*L'embauchage:* L'infirmière choisie et qui accepte les conditions de travail, doit fournir les certificats d'usage, lesquels sont ensuite vérifiés. Notons ici, les conditions de travail de l'infirmière :

Heures de travail: 8½ hres a.m. à 5 hres p.m. Une heure et demie est allouée pour le dîner.

L'infirmière entre au local chaque soir à 4½ hres, pour compléter les rapports de sa journée.

La semaine de cinq jours de travail.

Des barèmes de vacances et jours de maladie augmentant avec les années de service.

Echelle de salaire modifiée avec les exigences du coût de la vie. Augmentation de salaire annuelle à date fixe.

*Qualifications requises:* Infirmière licenciée — au moins un an de pratique de sa profession. Beaucoup d'initiative, bon jugement, santé parfaite, franchise absolue, douée d'un grand esprit de foi et de charité.

*L'entraînement:* Etude de la politique de l'organisation; de la technique adaptée dans le service; des services sociaux existants dans la ville; des dossiers et fiches en usage dans le service. Puis, l'entraînement proprement dit chez les malades.

*La spécialisation:* Exigée pour les infirmières destinées à remplir des postes de commande.

*L'évaluation du travail:* Se fait après les trois premiers mois; puis, deux fois par année. Ainsi, l'infirmière désireuse d'arriver à mieux, d'améliorer sa personnalité, à la satisfaction, tout au moins, de sentir que les autorités de l'organisation pour laquelle elle donne la majeure partie de ses journées, prend connaissance de ses efforts et de ses succès dans l'accomplissement de sa tâche.

En terminant, je me permettrai d'ajouter que le choix des nouvelles infirmières devient un peu plus difficile. Les "bons sujets" se font plus rares.

Cette carrière, d'une féminité si intense, dont la femme a voulu faire

Mlle Rivard est la directrice de cette Société à Montréal.

sienne, "puisqu'elle est fait pour le dévouement sensible" de dire le R. Père Legault, C.S.C., ne s'exemptera donc pas du tourbillon vaporeux de la vie actuelle?

L'infirmière ne doit pas s'y laisser prendre. L'orientation qu'elle a consenti à donner à sa vie, en vue d'une

meilleure administration, doit l'inciter à améliorer constamment sa personnalité, comprendre davantage, développer et raffermir les principes de formation qu'on nous enseigne, mais que nous n'admettons réellement qu'au cours de nos années de pratique. L'amour et l'effort en seront les grandes solutions.

## My Complaints

ANNE DALTON

I HAVE TWO COMPLAINTS to make and not only are they of importance but they involve a great number of people. The first is the expression on people's faces! You cannot expect too much of relatives, you can only talk to them and hope they will understand. But you should not have to tell doctors and nurses about their morbid leers. In the past few weeks, critically ill patients have been in my care and what exasperated me beyond words was the endless stream of nurses and orderlies slipping into the room to see the tragedy. It made me think of crowds gathering to see an accident on a street corner. No, they did not come to learn; they came to look! That was bad enough, but worse, not one of the onlookers ever smiled! They would come into the room, look very startled, and then, that expression which tells the patient he is doomed would slowly

creep over their faces. Sometimes these insensitive people would shake their heads!

This leads to my second complaint. You would not believe this but I heard a staff doctor say in front of my patient "He is going to die." Mind you, the patient was in oxygen but to me that made no difference; he was conscious and watching us. Another doctor said "There is nothing we can do." I actually heard a nurse, with a pained expression on her face, say "He is on his way out now." This sort of thing is shocking! stupid! and unfeeling! Even if a patient is only semi-conscious, nurses and doctors should be cheerful and, in front of the patient, say only what they themselves would like to hear if they were ill.

I remember as a student nurse going to the Montreal Neurological Institute and seeing a nurse smiling and chattering away to a patient who had been unconscious for three months. I never knew her, but she has my deepest respect and admiration. God bless her!

Miss Dalton, who was in the 1954 graduating class of the Royal Victoria Hospital, Montreal, is engaged in private nursing in Toronto.

## Les Infirmières des Salles d'Opération

LE 7 NOVEMBRE 1955 à 7:45 du soir avait lieu à l'Hôtel-Dieu de Montréal, une assemblée ayant pour but d'aider les infirmières qui travaillent dans les salles d'opération. Quatre-vingt-huit infirmières assistèrent à cette assemblée bilingue.

Mlle Flanagan et Mlle Merleau, Présidente, Association de la Province de Québec, ont souhaité succès et encouragèrent le

groupe. Mlle Trottier, présidente de ce groupe a donné l'histoire de cette nouvelle organisation.

Le but principal de cette réunion était l'élection des officières de ce groupe. Présidente, Soeur Louis d'Anjou, Hôpital du Sacré-Coeur, Cartierville; vice-présidente, Mlle M. Warnock, Hôpital Royal Victoria; secrétaire, Mlle C. Brault, Hôpital Notre-





*Operating Room Supervisors*

*(Jacques Doyon)*

Dame; trésorière, Soeur Michaud, Hôpital Hôtel-Dieu; relations extérieures, Mlle V. Crouse, The Montreal General Hospital; conseillères, Mlle Ena O'Hare, St. Mary's Hospital, Soeur Thérèse, Hôpital Hôtel-Dieu, Mlle Lefebvre, Hôpital St-Luc.

Beaucoup de questions concernant les problèmes des salles d'opération ont été soumises au comité exécutif et seront discutées dans les prochaines assemblées.

Ce groupe a été organisé avec le désir de maintenir la plus grande compétence possible dans ce champ du nursing. Ainsi, ce sera un moyen efficace de discuter les problèmes des salles d'opération et enseigner aux infirmières qui se destinent à travailler dans ce champ les plus récentes découvertes et développements des salles d'opération.

VIVIAN CROUSE

## Operating Room Nurses

A MEETING TO ORGANIZE the operating room nurses was held at the Hotel Dieu Hospital, Montreal, in November. This was a bilingual meeting with 88 persons in attendance.

The group was given a message of greeting and encouragement from Miss Merleau, President of the Association of Nurses for the Province of Quebec, and from Miss Flanagan. Miss Trottier, president of the group, gave a report on the history of this organization.

The election of officers was the principal matter of business. They are: president, Sister Louis d'Anjou, Hôpital du Sacre Coeur, Cartierville; vice president, Miss M. Warnock, Royal Victoria Hospital; secretary, Miss C. Brault, Hôpital Notre Dame;

treasurer, Sister Michaud, Hôpital Hotel Dieu; public relations, Miss V. Crouse, The Montreal General Hospital; counsellors, Miss Ena O'Hare, St. Mary's Hospital, Sister Therese, Hôpital Hotel Dieu and Miss Lefebvre, St. Luc's Hospital.

A number of questions, dealing with operating room problems, were submitted to the executive committee. These will be discussed at future meetings.

This group has been organized with the desire to maintain the highest level of proficiency in this phase of nursing. It is a means for discussing operating room problems. It brings before the operating room nurses the newest trends and developments in the operating room.

VIVIAN CROUSE

**Convention Tour** — For those who are planning to take the Hawaiian tour following the CNA biennial meeting in Winnipeg, a slight change in plans is announced. **You will leave Vancouver on Tuesday July 3, at 2 p.m. and arrive back in Vancouver at 7 a.m. on Saturday, July 14.**

# Nursing Profiles

**Florence Mary Roach**, R.R.C., has been appointed dean of nursing education of the new department that has been established within the faculty of arts and science at Assumption College, Windsor, Ont.

A graduate of St. Michael's Hospital, Toronto, Miss Roach secured her certificate in teaching and administration in schools of nursing from the University of Toronto. After further study at Seton Hall University, South Orange, N.J., she was awarded a bachelor of science degree. Before joining the nursing service of the Royal Canadian Navy, Miss Roach had taught in Hamilton and at St. Boniface. Following her discharge from the services, where she had attained the rank of lieutenant-commander, she organized and administered a new hospital at Oakville, Ont. She then returned to St. Michael's where she qualified as a registered records librarian. Prior to her appointment to Assumption College, Miss Roach was in charge of the medical records department of the Wellesley Division of the Toronto General Hospital.



*(Freelang, Toronto)*

**FLORENCE MARY ROACH**

**Dorothy Cox** who, for the past eleven years, has been with the Department of Health of Prince Edward Island, has joined the World Health Organization for service in India. Her new work will be in the

school of nursing at the J. J. Hospital in Bombay where she will help to integrate public health nursing into the basic curriculum and will take some part in the planning of field experience.

A Prince Edward Islander by birth, Miss Cox is a graduate of the Massachusetts General Hospital and of the course in public health nursing from the University of Toronto. Later, she obtained her degree in nursing from the McGill School for Graduate Nurses. She spent two years with the Nova Scotia Department of Health; then during World War II returned to P.E.I. where she organized the provincial venereal disease control program.

Miss Cox is a past-president of the Association of Nurses of Prince Edward Island.



**DOROTHY COX**

**J. Frances Ferguson**, who has served as the registrar-consultant and general supervisor of the School for Nursing Aides in Calgary since its inception in 1946, was chosen, under the Colombo plan, to set up a similar school in Ceylon.

A graduate of Royal Alexandra Hospital, Edmonton, Miss Ferguson took postgraduate work in pediatric nursing at Montreal Children's Hospital. She remained on the staff there until her enlistment with the Royal Canadian Army Medical Corps in 1942. She served in England, France, Belgium and Holland. She joined the Canadian Voca-



FRANCES FERGUSON

tional Training staff soon after her return from overseas.

Miss Ferguson gave splendid leadership to the Alberta Association of Registered Nurses during her two years as president. She has been very active, both nationally and provincially, in committee work chairing the Arrangements Committee for the 1954 CNA convention.

**Christina Murray Macleod** was honored recently by the Brandon Association of Graduate Nurses when a gift of money was presented to her as an expression of affection. In making the presentation the president of the local association said:

"This is evidence of our love and esteem for you, and to reassure you that we are aware that we have all benefitted greatly from having had the privilege of your direction. You have always held very high stand-



CHRISTINA M. MACLEOD

ards for the nursing profession before us. Ever since we learned of your accident we have wished to show you our love."

Miss Macleod, who retired from the post of director of nursing at the Brandon General Hospital in 1945, sustained serious injuries when she was knocked down by a car in Winnipeg in May, 1955. After a lengthy period of hospitalization she has made a remarkable recovery to the joy of her large circle of friends. Miss Macleod has always taken a very active interest in nursing affairs since she graduated from B.G.H. in 1908. We look forward to seeing her at the CNA convention in Winnipeg in June.

## In Memoriam

**Esthaol T. Bagshaw**, who graduated from The Montreal General Hospital in 1913, died at Hawkestone, Ont., on November 24, 1955. Miss Bagshaw served overseas during World War I with No. 8 Canadian General Hospital. Following the war she was at the Special Hospital at Buxton for a year before returning to Canada. She served on the staff at Westminster Hospital, London, Ont., retiring in 1946.

\* \* \*

**Margaret Mary Burns**, who graduated from St. Joseph's Hospital, London, Ont., in 1922, died at Sarnia, Ont., on December

24, 1955, at the age of 55. A graduate in public health nursing from the University of Western Ontario, Miss Burns was with the Lambton County Health Unit for 20 years.

\* \* \*

**May Elizabeth Fretz**, who graduated from the Public General Hospital, Chatham, Ont., in 1927, died at Chatham on November 27, 1955.

\* \* \*

**Christine (Musselman) Harrison**, who graduated from the Vancouver General Hospital in 1916, died at Edmonton on



December 9, 1955. Prior to her marriage in 1919, Mrs. Harrison was matron of Archer Memorial Hospital, Lamont, Alta.

\* \* \*

**Josephine F. Kilburn**, who graduated from the Toronto General Hospital in 1916, died at Vancouver on December 23, 1955. She was 65. After graduation, Miss Kilburn joined the Ontario Department of Public Health for a few years, then went to Johns Hopkins University to study mental health work. Returning to Toronto, she headed Ontario's first mental health organization. In 1930 she moved to Vancouver and assisted in setting up the first child guidance centre there. She was head of the social work department at the Provincial Mental Hospital, Essondale, until her retirement five years ago.

\* \* \*

**Antoinette Morin** died at Montreal on November 27, 1955. For many years Miss Morin was the district nurse in the Vassan area in the Province of Quebec.

\* \* \*

**Elva (MacKenzie) Rankine**, who graduated from Victoria Public Hospital, Fredericton, N.B. in 1939, died on November 18, 1955, at Fredericton, following a prolonged illness. She was 39 years of age.

\* \* \*

**Elizabeth Mary Redmond**, a graduate of the General Hospital, St. John's, Nfld., died on November 6, 1955. Miss Redmond was night supervisor at the General for many years.

\* \* \*

**Flora Mary (Phillips) Rice**, a graduate

of the Hospital for Sick Children, Toronto, died at North Bay, Ont., on December 4, 1955. For 25 years Mrs. Rice served as assistant superintendent at Muskoka Hospital, Gravenhurst, Ont.

\* \* \*

**Ethel G. Saunders**, who graduated from St. Joseph's Hospital, Victoria, in 1906, died at Victoria on December 7, 1955. Miss Saunders went overseas with the C.A.M.C. during World War I, serving at Gallipoli and Salonika and later in France and England. She was appointed matron of the military hospital at Work Point barracks, Victoria, following her return to Canada, transferring later to the Winnipeg military establishment.

\* \* \*

**Rita Madeline (Leach) Scott**, who graduated from the General Hospital, Regina, Sask., in 1931, died at Edmundston, N.B., on November 19, 1955, after a long illness. Mrs. Scott served in various centres in Canada with the R.C.A.F. during World War II.

\* \* \*

**Margaret Sivell** died at Moose Jaw on November 26, 1955 at the age of 81. For nine years Miss Sivell practised nursing in and around Moose Jaw. In 1920 she joined the Travellers' Aid in Regina. Poor health forced her retirement from that work in 1947.

\* \* \*

**Clara (White) Willis**, who served as an army nurse during World War I, died at Vernon, B.C., on December 12, 1955, at the age of 83.

## The Mind changes the Stance

It has been said that practically everyone working in physical therapy is thoroughly dissatisfied with the present results in posture training. The reason is partly because the wrong things are taught and partly because the whole concept of posture training is wrong.

The basic point which is being overlooked in most remedial work is that it is behavior not structure which determines the mechanics of the body. A person's muscular tensions are a fundamental part of his defence against the world. Under tension, a person will rapidly revert to his old tension state and to the old posture associated with it. For example, the posture of submission to authority is slight cringing. Only through re-

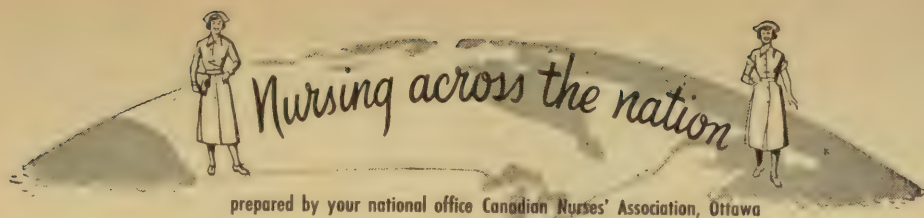
education of these behavioral attitudes can mechanical faults be altered.

— *Lancet*

\* \* \*

A flange-type rubber stopper for bottles that permits autoclaving of fluids is a device created recently. The new stopper gives hospitals, that manufacture their own intravenous solutions, a simpler and more convenient bottle closure. Since the stopper can be re-used, the economy factor is another of its important features. Recent tests show no change in performance after frequent sterilization and the researchers feel that it can be re-used many times over.

— *Fentcal Laboratories Inc*



## *To and Fro*

**A**PPPLICATIONS FOR TEMPORARY salaried employment from 85 foreign nurses were received in National Office during 1955, as part of the International Council of Nurses' Exchange Program. Twenty Canadian nurses took advantage of this program in securing additional nursing experience abroad.

In addition, the Department of Immigration reports that for the first nine months of 1955, 906 nurses emigrated to Canada. Of these 625 were British, 58 German, 54 Dutch, and 51 from the United States.

To balance this, 849 professional nurses and 31 student nurses left Canada for the United States during the U.S. fiscal year ending June, 1954. Since 1946 an average of 737 Canadian nurses have emigrated to the U.S. yearly.

Nurses form the largest professional group emigrating to the U.S. from Canada while engineers are the second largest group.

## *A Visitor to National Office*

One of the 85 nurses securing temporary employment in Canada, under the I.C.N. Exchange Program, visited National Office recently. She is Miss Lurline Walters.

A Jamaican nurse, Miss Walters was granted leave of absence to come to Canada to gain experience in the nursing care of patients with poliomyelitis. Her first six months were spent in the University of Alberta Hospital, Edmonton, where she rotated through various units providing experience most valuable to her. This was followed by observation and study in Toronto, Ottawa and Montreal.

Upon her return to Jamaica, Miss

Walters will be employed at the Kingston General Hospital.

We should like to record here our appreciation to the provincial nurses' associations and to staffs of health agencies for their assistance in planning interesting and helpful experiences for our visitors from abroad.

## *Project in International Nursing*

December marked the launching of a new project in international nursing, when a nurse from British Guiana began a year's intensive experience in Canadian hospitals.

As noted in our November column, Miss Joyce Owen, a ward sister at the Public Hospital, Georgestown, British Guiana, was awarded the Kitchener-Waterloo Rotary Scholarship. Upon her arrival at Malton Airport she was met by Miss Frances McQuarrie, C.N.A. Nursing Education secretary, and Mr. C. A. Pollock, chairman of the International Service Committee of the Kitchener-Waterloo Rotary Club. Experience in the field of psychiatric nursing will include periods of study in Kitchener, St. Thomas, Toronto, Montreal and Ottawa.

## *Yearbook of Modern Nursing*

The first annual Yearbook of Modern Nursing is to be published by G. P. Putnam's Sons of New York this month. To quote from the purpose of the Yearbook, it will be designed:

1. To provide the medium in which progressive thinking is pooled.
2. To prepare annually, in book form, a resume of the advancement of nursing in all its aspects, especially as it pertains to improved practice. A broad range of topics is included in recognition of the newer patterns which are constantly emerging.

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in clinical  
enzymology*

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Interest in Canadian nursing is such that National Office was asked to submit a summary of developments of nursing in Canada during 1955. Others also asked to contribute to this publication are WHO, Pan-American Sanitary Bureau and the ICN.

### *Encyclopedia Canadiana*

A new edition of the Encyclopedia Canadiana is now being prepared. The present edition was compiled in the 1930's. Once again the CNA has been asked to prepare an article on the Nursing Profession in Canada. This article, dealing with the early beginnings of our profession and reviewing the developments and achievements

over the years, has been submitted. When published, the new edition will contain much up-to-date information on Canadian nursing.

### *Telling the R.N.A.O. Story*

April 12, 13, and 14 the Registered Nurses' Association of Ontario will hold its annual meeting at the Royal York Hotel, Toronto. A panel on Public Relations will be held with the CNA's public relations counsel, Mr. John Fry, participating. The panel "Telling Our Story" will discuss general principles of public relations with their application to various nursing fields outlined by the other participants.

## *Le Nursing à travers le pays*

### *Ca et Là!*

Des demandes d'emplois temporaires et rémunérés furent reçues au Secrétariat national en 1955, d'infirmières bénéficiant du programme d'échange du Conseil International des Infirmières. Vingt infirmières canadiennes participeront également à ce programme et iront en Europe afin d'étendre leur expérience.

Le Ministère de l'Immigration rapporte qu'en 1955, au cours des neuf premiers mois de l'année, 906 infirmières ont immigré au Canada: 625 venant de Grande-Bretagne, 58 d'Allemagne, 54 de Hollande et 51 des Etats-Unis. Dans le même temps, 849 infirmières canadiennes et 31 étudiantes-infirmières émigrèrent aux Etats-Unis. Depuis 1946, annuellement, 737 infirmières quittent le Canada pour les Etats-Unis.

Les infirmières forment le groupe le plus important émigrant aux Etats-Unis; elles sont suivies de près par les ingénieurs.

### *Une visiteuse au Secrétariat National*

Une infirmière, bénéficiant du programme d'échange du Conseil International des Infirmières, visitait récemment notre Bureau national; il s'agit de Mlle L. Walters de la Jamaïque qui a obtenu un congé afin de venir au Canada acquérir quelque expérience dans le soin des enfants victimes de la polio.

Mlle Walters a passé les six premiers mois de son séjour au Canada dans les divers services de l'Hôpital de l'Université d'Alberta à Edmonton où elle acquies une expérience précieuse. Dans la suite elle a fait de courts

séjours d'étude et d'observation à Toronto, Ottawa et à Montréal; puisse-t-elle faire bénéficier son pays de l'expérience acquise dans le nôtre.

### *Projet en Nursing International*

Un nouveau projet a été lancé en décembre lorsqu'une infirmière de la Guyane anglaise est arrivée au Canada afin d'y poursuivre des études intensives dans les hôpitaux canadiens.

Cette infirmière, Mlle Joyce Owen, une surveillante dans l'Hôpital Public de Georgetown, en Guyane anglaise, s'est vu décerner une bourse d'étude par le Club Rotary des villes de Kitchener et de Waterloo, Ont. A son arrivée elle fut accueillie à l'aéroport par Mlle Francis McQuarrie, secrétaire du Comité national de l'Education en Nursing ainsi que par M. C. A. Pollock, président du Comité International de Service du club déjà mentionné. Mlle Owen se propose d'étudier la psychiatrie à Kitchener, St-Thomas, Toronto, Montréal et Ottawa.

### *Revue sur le Nursing moderne*

Un volume, revue de l'année sur le nursing moderne (Yearbook of Modern Nursing) vient d'être publié par la maison G. P. Putnam's Sons de New York. Le but que l'on se propose d'atteindre par cette publication est de:

1. Favoriser la mise en commun des idées de progrès et d'avancement.
2. Présenter dans une revue annuelle les progrès du nursing dans tous ses aspects et particulièrement dans le but d'en améliorer la pratique. Des sujets variés y sont traités pour

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démontrer les innovations qui se présentent sans cesse dans le domaine du nursing.

L'intérêt envers le nursing au Canada est tel que l'on a demandé au Secrétariat National d'écrire un article résumant les progrès du Nursing au Canada en 1955.

### *Encyclopedia Canadiana*

Une nouvelle édition de l'Encyclopedia Canadiana est en voie de préparation. L'édition actuelle date de 1930. Une fois de plus, l'A.I.C. a été priée de préparer un article sur la profession d'infirmière au Canada. Cet article, traitant des débuts de notre profession et relatant les progrès accomplis d'année en année,

a été soumis. Cette nouvelle édition contiendra donc des renseignements de toute dernière heure sur le nursing au Canada.

### *L'histoire de l'A.I.E.O.*

Au cours de la semaine du 12 avril prochain, l'Association des Infirmières enregistrées de l'Ontario tiendra son assemblée annuelle à l'Hôtel Royal York, à Toronto. Un colloque sur les relations extérieures aura lieu avec le concours de M. John Fry, conseiller en relations extérieures de l'A.I.C. et aura pour sujet: "Racontons notre histoire"; on y discutera les principes généraux des relations extérieures et leurs applications dans les différents champs d'activité de l'infirmière.

## Sélection

### **Quelques Nouvelles Tendances dans le Nursing en Hygiène Publique.**

**I**L Y A PLUSIEURS ANNÉES, on considérait comme une perte de temps que de centrer nos efforts sur le contrôle des maladies chroniques. Maintenant, nous savons qu'il est possible de prévenir et de traiter nombre de ces conditions.

En tant que collaboratrices importantes dans les programmes pour la prévention des maladies, les infirmières hygiénistes des services de santé, des industries et des écoles ont contribué d'une manière unique à presque chaque phase du travail de santé de la communauté.

Durant les vingt dernières années, des changements dans le domaine de la médecine clinique et de la pratique du nursing se sont opérés les uns à la suite des autres, avec une rapidité grandissante. Les sulfamidés, les antibiotiques, la médication endocrinienne, "le syndrome du Stress," les composés comme l'A.C.T.H. et la cortisone, plusieurs tests biochimiques nouveaux pour le diagnostic, le traitement et le contrôle des maladies, tout cela était inconnu il y a vingt ans.

Pour celles d'entre nous, de l'hygiène publique, qui avons eu notre expérience à l'hôpital il y a plus de dix ans, les développements survenus dans le nursing et la formation en nursing peuvent nous sembler bien différents et même intrigants. Le nursing

d'hygiène publique fut également sujet à des changements de techniques et eut à subir des contraintes pour ces changements, comme le nursing en médecine clinique, quoique, peut-être à un degré moindre. Nous avons été sûrement moins conscientes du changement car nous avons vécu au jour le jour avec la marche des progrès. Considérons, cependant, quelques-unes de ces nouvelles tendances du nursing en hygiène publique qui se sont développées depuis les dernières années et qui semblent importantes à l'avenir de l'hygiène publique.

#### MALADIES CHRONIQUES

Il y a plus de vingt ans, alors que les maladies dévastatrices étaient les maladies contagieuses aiguës, personne ne croyait que le contrôle des maladies chroniques put occuper une place prépondérante, dans un programme de santé communautaire. L'impression était "que rien de plus ne pouvait être fait," pourquoi alors perdre du temps? Durant ces dernières années, nous avons constaté que plusieurs choses pouvaient être faites sans "perdre notre temps." Un dépistage dès le début est maintenant le facteur clef dans le contrôle de plusieurs maladies chroniques. Nous n'attendons plus que l'évolution soit avancée à un point tel que des symptômes alarmants ou des complications surgissent avant que le patient ne demande l'assistance médicale. Comme exemple: par l'éducation de la population au sujet des dangers du diabète et des groupes

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Préparé par L'Ecole des Infirmières hygiénistes de l'Université de Montréal.  
Mattison, Berwyn F., *American Journal of Nursing*, août, 1954, p. 986.





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qui peuvent tout particulièrement en souffrir, par l'accès facile des services disponibles qu'offre la communauté pour un diagnostic précoce de la maladie, une attitude entièrement nouvelle est apparue.

L'infirmière hygiéniste, par sa part active dans les campagnes de dépistage des cas, par sa connaissance des types de diabète et encore plus, par sa fonction traditionnelle d'éducatrice du diabétique et de sa famille quant aux moyens à prendre pour vivre d'une manière satisfaisante avec cette maladie, a contribué grandement à la prévention, non de la maladie elle-même, mais des mortalités et des incapacités qui autrement auraient pu en résulter.

Avec l'accroissement de la longévité de la population et l'élimination des maladies aiguës qui habituellement causaient la mort à l'âge mûr, le cancer, comme le diabète, a pris une place de plus en plus importante dans les cadres de la santé. Ici aussi, l'une des approches les plus nouvelles est de se baser sur des enquêtes épidémiologiques. Une connaissance des formes de cancer les plus fréquentes, la possibilité de dépister les individus les plus prédisposés à souffrir des types de cancers malins, et l'opinion du public à ce sujet, tout cela contribue à la solution du problème.

Un autre exemple d'un procédé préventif, de grande envergure développé durant les dix dernières années, est le dépistage des tumeurs pulmonaires, des maladies du cœur aussi bien que de la tuberculose, par des radiographies en masse, des poumons, c'est-à-dire par des programmes organisés sur une haute échelle. Ici encore, il y a de nouvelles techniques qui supposent une interprétation différente et beaucoup de compréhension de la part de l'infirmière afin qu'elle puisse tenir les gens de sa localité au courant de ces développements.

#### HYGIÈNE MENTALE

Cette sphère a pris une importance nouvelle dans les cadres du nursing en hygiène publique au cours des dernières années.

Tout comme le psychiatre moderne qui dispose maintenant d'un ensemble de méthodes thérapeutiques efficaces dans le traitement des maladies mentales, de même le praticien d'hygiène publique a en mains de nouvelles armes pour la prévention de plusieurs troubles émotifs et des mésadaptations. Les modes "d'introduction de l'agent immunisateur" contre les troubles émotifs peuvent être: la consultation pour enfants sains, la consultation psychologue-parents-

enfants, l'éducation sur les origines habituelles des troubles émotifs et des mésadaptations ou, tout simplement, le contact personnel et les discussions de l'infirmière visitant un domicile, un parent ou un enfant. Mais si ce sont là les modes d'application vous devez vous demander: qu'est-ce donc que l'agent immunisateur? En un mot, c'est la compréhension.

Comprendre pourquoi les gens réagissent de la façon dont ils le font; comprendre de quelle manière les divers comportements se développent durant l'enfance; comprendre comment, dans nos contacts avec les patients, nous réagissons envers eux et, ensuite, comment ces réactions peuvent affecter le patient.

Toutefois, comprendre les développements émotifs et les réactions n'est pas chose facile. Quelques-uns peuvent y parvenir naturellement; d'autre, avec de l'intérêt et de la sympathie peuvent y réussir; et d'autres, fort probablement n'y parviendront jamais. Mais dans le champ du nursing en hygiène publique, il est sûrement désirable, que nous nous efforcions d'y parvenir.

Chaque fois que nous avons une entrevue avec un patient, chaque fois que nous visitons un domicile, chaque fois que nous dirigeons une clinique, l'application de cette compréhension des réactions personnelles des individus ne fera que rehausser la valeur de toutes les autres choses que nous faisons.

Et ceci ne s'applique pas seulement à l'enfant. Persuader un tuberculeux d'accepter l'hospitalisation, l'encourager à rester à l'hôpital même à la suite d'un séjour prolongé, inciter le patient atteint de poliomyélite à travailler fort afin de parvenir à redonner la vigueur à ses muscles, ou bien redonner l'espoir et le désir de vivre à la personne atteinte d'une maladie chronique sérieuse, dans tout cela nous avons besoin de comprendre les réactions personnelles des individus.

Peu importe si oui ou non nous désignons ce procédé sous le nom de "relations interpersonnelles," pourvu que nous employions ces techniques régulièrement chaque jour, de part et d'autre.

L'approbation des mesures par lesquelles nous pouvons établir un système déterminé pour classer ces connaissances et les trois moyens de pouvoir les employer plus fréquemment, est l'un des nouveaux développements, mais non les méthodes proprement dites.

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munautaire avec lequel le nursing en hygiène publique est déjà intimement lié.

La part du nursing dans tout programme de défense civile quel qu'il soit est naturellement une des plus importantes. Des cas sinistres semblables et différents de ceux que nous sommes habituées de traiter vont nous être présentés en nombre incroyable. A l'hôpital, l'improvisation d'installations médicales et le traitement de ces cas sinistres seront établis d'une manière orthodoxe. Mais tout le problème concernant le nombre et l'organisation d'installations médicales et l'entraînement du personnel de manière à ce qu'il soit présent et puisse collaborer au moment d'une urgence est un problème communautaire.

C'est l'un de ces problèmes communautaires que les infirmières hygiénistes ont très bien solutionné dans le passé. Cela ne diffère pas tellement des programmes communautaires organisés pour l'immunisation antidiptérique ou les improvisations connues des infirmières des centres ruraux qui consistent à établir des cliniques à des endroits qui ne furent jamais destinés à une telle installation; c'est le même genre de problème dans l'éducation des groupes que l'infirmière hygiéniste a résolu au moyen de classes aux mères et à d'autres groupes. C'est maintenant une part de la responsabilité de la collectivité aussi bien que l'est le contrôle de la tuberculose et l'hygiène scolaire.

Il y a une participation spécifique de la part des infirmières hygiénistes lors d'un désastre civil. Dès les premiers instants, il est probable que leurs premières fonctions seraient d'appliquer les principes fondamentaux du nursing. Mais, plus tard, elles seraient appelées à établir des unités d'infirmes dans les centres d'évacuation, à organiser des cliniques si une grande partie de la population devait être protégée contre la typhoïde ou le tétanos, et fournir des centres pour le soin des enfants afin d'éviter la perte inutile de centaines de bébés.

#### EDUCATION DES GROUPES

L'éducation des groupes est aussi un nouveau champ d'action dans le nursing en hygiène publique, du moins, en ce qui concerne l'évolution de ses applications. Avec l'accroissement de la population et les besoins grandissants de certains groupes spéciaux en matière de santé, et avec le territoire bien défini qu'a à desservir l'infirmière hygiéniste, l'éducation des groupes est de

plus en plus employée. Certainement, que l'éducation de groupe n'est chose nouvelle pour les infirmières hygiénistes, mais il y a quelque chose de plus que l'éducation du groupe dans le progrès de ce processus.

Auparavant, une infirmière ou un médecin faisait une conférence devant un groupe de parents au sujet des problèmes de leur enfants ou encore, des conférences à un groupe d'adultes sur les risques de cancer, etc. Récemment on a démontré qu'en ce qui concerne particulièrement les maladies émotives, il est important de créer l'intérêt chez les participants afin de leur faire une part active au programme d'éducation de leur groupe. C'est un besoin pour les individus de discuter leurs problèmes, de parler de leur inquiétudes et d'entendre d'autres qui sont dans la même situation faire de la sorte.

Cette participation personnelle aide un individu à réaliser que ses problèmes et réactions ne diffèrent pas tellement des problèmes et des réactions de nombre de personnes qui sont dans la même situation. Et peut-être qu'une grande part du succès de la participation de l'individu à l'éducation d'un groupe vient du désir d'aider autrui: cela semble être le facteur principal qui ressort d'un tel procédé. Ceci et probablement nombre d'autres facteurs se greffent à une toute nouvelle technique pour les travailleurs en hygiène publique, celle-ci requérant un entraînement spécial mais pouvant produire des résultats incroyables si elle est employée d'une manière satisfaisante.

#### QUELQUES PROGRÈS RÉCENTS

La nécessité pour l'infirmière scolaire ou industrielle de s'intéresser à la santé individuelle au foyer aussi bien qu'à l'école et à l'industrie n'a pas à être discutée de nouveau.

En corrélation, il existe une seconde tendance qui est certainement très bonne: c'est la coopération entre les hôpitaux et les services communautaires. Pendant trop d'années, l'infirmière en service à l'hôpital ne devait s'occuper que du patient lorsqu'il était hospitalisé. Depuis longtemps, on a accepté le principe que le patient devrait être considéré comme un individu, et son séjour à l'hôpital, simplement comme un incident survenu dans les cadres de sa vie habituelle. En maintes circonstances cependant, les infirmières n'étaient pas informées sur la manière de relier les problèmes du patient hospitalisé à ceux de son foyer; elles n'étaient pas au courant non plus des ressources communautaires qui peuvent aider à résoudre ces problèmes une fois retourné chez lui.



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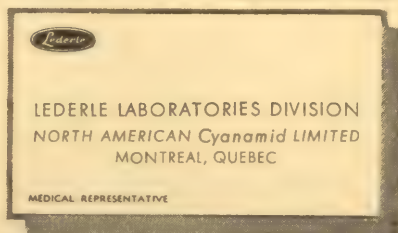
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Maintenant que des infirmières hygiénistes coordonnatrices font partie du personnel du nursing de l'hôpital on veut que le personnel administratif ait de l'expérience dans les organisations de santé communautaires, cette fâcheuse conception de considérer le patient hospitalisé comme une personne à compartiments est près de sa fin. Beaucoup reste à faire, mais un commencement a été fait.

Une autre expérience intéressante pour plusieurs infirmières hygiénistes est "l'échange mondial" des idées sur la pratique du nursing, expérience rendue possible par l'échange d'infirmières venant d'autre pays. Ce programme a été secondé par l'Organisation Mondiale de la Santé, par le Conseil International des Infirmières, l'Association

des Infirmières canadiennes et des organisations privées.

De cette manière, nous pouvons peut-être aider certains peuples moins privilégiés à améliorer leur santé par de meilleurs soins, et nous pouvons certainement apprendre de celles qui viennent de pays où certains services du nursing sont hautement développés. Mais le plus important pour nous est que nous y gagnons une nouvelle façon d'apprécier ces progrès que nous considérons comme octroyés. C'est seulement en entendant raconter de vive voix les conditions de santé des pays moins fortunés et le manque de facilités modernes pour les services médicaux et ceux du nursing en ces pays, que nous pouvons situer clairement notre contribution à la santé de la population de notre pays.

## Alberta S.N.A.

The Student Nurses' Association of this province has developed a program of activities which should produce a group of well-informed young women. Their interests range through citizenship, professional duties and responsibilities, student recruitment and promotion of interest in professional organizations.

A film strip and booklet on nursing are currently being considered as projects in providing material for recruitment. A study of provincial association and C.N.A. objectives is contemplated. It is especially interesting to note that, in connection with this study, the possibility of dominion registration examinations is to be explored. In these days of extensive travel, Canadian nurses are constantly seeking information regarding registration and working conditions in other provinces and countries. The association plans to make such information available to its members through the efforts of its Graduate Nurse Activities committee.

The question of financial support, often a problem to nursing students, may be partially solved by a projected survey of the bursaries and scholarships presently available through governmental and other sources. An interest is also being taken in increasing the effectiveness and uniformity of student government. Professional duties and responsibilities are best discharged when the individual nurse has a proper perspective of herself as a citizen of a community. With that object in mind, students are being encouraged to get to know each other better

on a provincial and national level. They are given the opportunity to participate in activities affecting the profession as a whole rather than just the individual school. The Inter-Hospital Relations Committee directs its efforts solely toward this goal. A newsletter committee has undertaken the responsibility of publishing three or four editions annually so that all students may be kept aware of developments in the various schools of nursing.

The association plans to hold its annual convention in May, 1956. The progress of this ambitious group should be an inspiration to similar organizations across Canada.

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In many parts of the world, the most severe limitation upon improved medical care is the woefully inadequate numbers of trained doctors and nurses and the scarcity of facilities for high quality medical education. Although there are many fellowship opportunities . . . which can be used for medical training abroad and although many are studying abroad at their own expense, the number of doctors and nurses who can be trained outside their own countries is pitifully small in relation to the need. Good medical schools are needed . . . both to assist in training the medical personnel required and to bring the resources of scientific medicine specifically to bear upon the diseases and other health problems of the local environment.

— *The Rockefeller Foundation, Annual Report, 1954*



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## Convention Personalities

**Adelaide (Macdonald) Sinclair, O.B.E.**, who is executive assistant to the Deputy Minister of National Welfare, Department of National Health and Welfare, is very well known to hundreds of Canadian women who served with the Royal Canadian Navy during World War II. As director of the W.R.C.N.S., with the rank of captain, Mrs. Sinclair played a major role in the development and over-all supervision of this efficient service.



*(Bradford Brachrach, Ottawa)*

**DR. ADELAIDE SINCLAIR**

Following the organization of the United Nations, Mrs. Sinclair became the Canadian delegate to UNICEF, a post she still holds. She was chairman of UNICEF's program committee from 1948 to 1950 and chairman of the Executive Board in 1951 and 1952. She was delegate to the UNESCO meetings in 1947 and alternate delegate to the UN General Assembly in 1950.

Mrs. Sinclair's interest in the problems currently facing the nursing profession has a solid foundation in her long years of study and work in the field of social work and political science. In tribute to her leadership in these fields, two universities have awarded her honorary degrees. Her own alma mater, the University of Toronto, where she secured her M.A. in 1925, presented her with an honorary LL.D. in 1946. Six years later, Laval University at Quebec made Mrs. Sinclair an honorary Doctor of Social Science.

Another outstanding speaker during the convention this year will be **Margaret G. Arnstein**, chief of the Division of Nursing Resources of the United States Public Health Service. Graduating from Presbyterian Hospital, New York City, in 1928, Miss Arnstein turned immediately to public health nursing, the field wherein she has given such conspicuous leadership over the years. She secured her M.A. from Teachers College, adding later her M.P.H. from Johns Hopkins University. When she had completed the work for the latter degree, majoring in epidemiology, Miss Arnstein became communicable disease consultant in the New York State Department of Health. She moved on to become director of the program for public health nurses at the University of Minnesota. During the three years she was there she collaborated with Dr. Gaylord Anderson in writing a textbook entitled "Communicable Disease Control."

Miss Arnstein returned to New York City as district consultant of the State Health Department. In 1941, she was loaned to the U.S.P.H.S. to set up the first program of federal grants to schools of nursing — the precursor of the Cadet Nurse Corps program. She was also state nurse in the Office of Civil Defence at that time. Given leave of absence to join UNRRA, Miss Arnstein spent 15 months in the Middle



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Entering the U.S. Public Health Service in 1946 as assistant to the chief of the Division of nursing, Miss Arnstein moved into her present position three years later. She was loaned to the World Health Organiza-

tion for two months during the winter of 1950-51, during which time she prepared a manual entitled "Guide for National Studies of Nursing Resources." The purpose of this manual was to assist nations to study their own nursing services in their broadest aspects.

## Book Reviews

**Babies are Human Beings**, by C. Anderson Aldrich, M.D. and Mary M. Aldrich. 122 pages. The Macmillan Co. of Canada Ltd., 70 Bond Street, Toronto 2, Ont. 2nd Ed. 1954. Price \$2.95.

*Reviewed by Miss Nancy Pearson, Infant Clinical Supervisor, Montreal Children's Hospital, Montreal.*

Dr. and Mrs. Aldrich have for many years studied child growth and development and its implications for the better understanding care of children. The revised edition of "Babies are Human Beings" follows the same theme as the original book. It is even more fascinating, useful and practical. Dr. Aldrich has delved into the fields of medicine, physiology, psychology, philosophy and education in order to gain some insight into the phenomenon of growth and its importance in understanding the behavior of children. In the early years of childhood, mental and physical functions cannot be separated. To the degree to which the infant's early needs are considered rests his future ability to feel secure in a changing world.

In the early chapters the physical appearance and behavior of the newborn infant is described. All babies are different and variations in behavior call for individual management. Dr. Aldrich endeavors to interpret the reasons for such wide differences in each baby's feeding habits, sleeping patterns, elimination and social responses. Finally the effect of this early understanding on the older child are mentioned briefly because "to leave the infant high and dry at two years of age would ignore growth's ultimate purpose, the attainment of maturity."

"Babies are Human Beings" is written primarily for parents but nurses and all others dealing with infants and young children should find this book full of common sense and useful information. It will help

to further their understanding of these young human beings.

**Gynecology for Senior Students of Nursing**, by John Cairney, D.Sc., F.R.A. C.S. 211 pages. N. M. Peryer Ltd., Christchurch, New Zealand. 1954.

*Reviewed by Mrs. Jean Baker, Clinical Instructor, Western Hospital, Toronto, Ont.*

The author states in the preface that his aim is to present a reasonably complete survey of modern gynecology with sufficient explanation to make it intelligible to the senior student or graduate nurse. At the same time he wished to restrict the volume to modest dimensions.

Since Dr. Cairney is in Australia, there is bound to be a diversity in the manner of treatment of certain conditions. For example, while he infers that the treatment of carcinoma of the uterus is open to controversy, he makes little reference to the possible value of irradiation. In the chapter on general postoperative treatment, some differences are striking. Ambulation is remarkably late when compared to our present practices. Treatment and nursing care of a patient following vaginal surgery is so general as to be almost valueless. The chapter "Carcinoma of the Reproductive Tract," proved quite disappointing. It appears to be an incomplete outline. Primary carcinoma of the ovary is omitted entirely.

Otherwise the material seems complete and lucid. The chapters appear in good sequence. His presentation is clear and forceful. The explanation of meanings and derivatives of names of organs and associated terms are particularly enjoyable. Dr. Cairney has dealt with each of them logically when the term first appears. Another feature of special interest is the chapter on "Pregnancy, Labor and the Puerperium." Its inclusion seems quite reasonable since many

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# Royal Canadian Navy

gynecologic disorders occur as a result of or in conjunction with pregnancy.

As methods of training differ from country to country, his book might be suited to the Australian student or graduate. That it would be of special value to our advanced students is doubtful. He has, however, succeeded in producing a more complete account of the subject than is usually found in textbooks of surgery for nurses. For this reason, this book would be of value in a general reference library for students and graduates.

#### **Demonstrations of Operative Surgery,**

A Manual for General Practitioners, Medical Students and Nurses, by Hamilton Bailey, F.R.C.S., F.A.C.S. 387 pages. The Macmillan Company of Canada Ltd., 70 Bond Street, Toronto 2, Ont. 2nd Ed. 1954. Price \$4.10.

*Reviewed by Sister Paul of the Cross, Surgical Supervisor, Charlottetown Hospital, Charlottetown, P.E.I.*

This second edition consists of artistically written and beautifully illustrated material. The work is divided into eleven sections. The first is entitled "General Principles" and deals with description of instruments and surgical equipment, their proper use, care and sterilization. The following ten sections, divided according to body systems, consist of description and illustration of more than 70 common operative procedures.

The descriptions are prefaced by very interesting clinical summaries which answer the question: "Why is this operation being done?" The descriptions are given in a "living narrative" which paints a very vivid mental picture of the various procedures carried out by the surgeon. These are reinforced by conveniently placed and clearly demonstrative illustrations in black and white as well as color where indicated. The most amazing feature of this work lies in the enormous amount of detail possible in such a comparatively small volume. Nothing is left in doubt regarding the reasons for doing even the simplest procedure.

One cannot fail to highly recommend this text for reading and repeated reference by general practitioners, medical students and nurses for whom it was so capably prepared.

#### **The Birth of Industrial Nursing,**

by Irene H. Charley, S.R.N. 224 pages. The Macmillan Company of Canada Ltd., 70 Bond Street, Toronto, Ont. 1954. Price \$1.80.

*Reviewed by Miss Theresa Greville, Canada Packers Ltd., Winnipeg, Manitoba.*

Here is a book primarily intended to be of use to those concerned with occupational health services. The book is replete with well documented information on the growth and expansion of nursing services to men and women on the job, particularly in England. Phillippa Flowerday is given the honor of being the first industrial nurse — according to the modern concept.

Nursing services in England are described: In the mines, in the civil service, in air transport, on British railways, in the hopfields and among the fisher girls, etc.

This book is international in outlook and information. It should prove to industrial nurses everywhere that their problems to obtain the best care for men and women at their place of work are common basic ones which have to be met with wide knowledge and understanding. Above all, a brand of courage and integrity not always demanded in other branches of nursing is required. It would be false optimism to assume that industrial nursing service has reached its Golden Age. Nurses everywhere have to keep up the services started under difficult conditions and improve and adapt their nursing skills to changing needs. This book should be an inspiration to all nurses.

#### **Essentials of Pediatrics,**

by Philip C. Jeans, A.B., E. Howell Wright, B.S., and Florence G. Blake, M.A. 808 pages. J. B. Lippincott Co., 2083 Guy St., Montreal. 5th Ed. Price \$4.75.

*Reviewed by Jean A. Cummins, Head Nurse and Clinical Instructor, Holy Cross Hospital, Calgary, Alta.*

The present co-authors have preserved the wisdom of the late Dr. Jean's long experience in the field of pediatrics while making the changes necessary to bring the contents up-to-date. Care has been taken to include all of the subject matter suggested in the curriculum for schools of nursing prepared by the National League of Nursing.

This new edition carries much new material on the psychologic development of the child from birth through adolescence. This is dealt with in Unit Two, under the headings of growth, development, care and guidance.

Unit Three discusses in detail the nurse-child and nurse-parent relationship. The authors have made an exceptionally good effort to view illness through the eyes of the child and his parents, that the nurse may better understand their reactions. A new chapter pertaining to fluid and drug



administration in a variety of common childhood illnesses has been included. Fluid balance and electrolyte therapy are clearly presented. Unit Four is confined to the disorders of the newborn. It is designed to help the nurse recognize the more significant factors with which she must concern herself. The more common conditions found in children are discussed under various body systems.

Unit Five deals with modern, up-to-date information on nutrition and nutritional diseases.

This fifth edition of a nursing classic maintains the high quality we have come to expect of this book. Its information is still sound, scientifically accurate and complete. Its thinking is adjusted to the changing concepts of pediatric care. It offers the graduate and student nurse a comprehensive coverage of the entire field of pediatric nursing.

#### Curriculum Study in Basic Nursing

**Education**, by Ole Sand, Ph.D. 225 pages.

G. P. Putnam's Sons, 2 West 45th St., New York City. 1955. Price \$3.75.

*Reviewed by Miss M. Jean Wilson, Asst. Professor, School of Nursing, University, of Toronto, Toronto, Ont.*

A five year curriculum research project is being conducted at the University of Washington School of Nursing. The objective is to determine the kind of curriculum, and the length of time required to educate an effective professional nurse in terms of what is best for society. Dr. Sand, the director of the project, presents this report on the developments during the first year and a half.

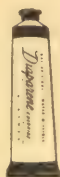
The ten chapters present, in a well organized form, methodology, formulation of objectives, a philosophy and theory of learning, and selection of learning experiences in the clinical area. The relationship of general and professional education and the social and natural sciences with clinical nursing is discussed. A theory of evaluation and a description of how the faculty works together follows. Next steps to be taken are outlined.

The major purposes of the report "are to describe the tasks upon which one faculty is working, and how the faculty is working together to accomplish these tasks in the hope that other schools of nursing, both collegiate and hospital, may find suggestions for the study of their own curriculum." Instructors and administrators of nursing



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education will find the concise, step-by-step presentation of material and the detailed exhibits in the appendix of assistance toward this end. The reader will wish to see ensuing reports. It will be of great interest to follow the further developments in this five year research project.

**Patterns of Patient Care, Some Studies of the Utilization of Nursing Service Personnel.** 266 pages. The Macmillan Co. of Canada, Ltd., 70 Bond St., Toronto 2, Ont. 1955. Price \$4.50.

*Reviewed by Miss Ida Johnson, Director of Nursing, Royal Alexandra Hospital, Edmonton, Alta.*

This is a very realistic presentation of the nursing needs — psychosocial and physical — of the patient and the supportive care that is given to meet these needs as they arise.

The data given on studies made to date in relation to patient care and nursing personnel is very informative. The chapter entitled "The Ward, The Patients and The Workers," serves as an introduction for the designing of the group pattern. The respon-

sibilities of the professional nurse, the practical nurse, the nurse's aide and the ward clerk are indicated also.

Nine patterns of patient care are described and evaluated. These give a basis for the construction of a master staffing pattern. Tables showing the average number of minutes of nursing care required by medical and surgical patients plus the formula for obtaining the number of persons — professional and non-professional — required offers constructive assistance to those planning nursing service coverage.

The authors, in the chapter "The Way Ahead," give labor-saving devices and implications for the hospital administrator, the director of nursing service and the head nurse. The appendix contains valuable statistics obtained from the study of nursing activities, personnel policies and orientation programs.

In the words of the authors "This blueprint for patient care will require development of new patterns of nursing service." The material presented will be invaluable for planning patterns of patient care in the challenging and promising future.

## In the Good Old Days

(*The Canadian Nurse* — March, 1916)

As the library in the nurses' home was meagre an arrangement was made with the city public library that the nurses' home would be a sub-station of the library. It was opened with 100 new books of fiction which are replaced each month with a fresh supply. This arrangement has made the library a mecca for tired student nurses.

\* \* \*

Particular attention should be paid to providing suitable outdoor exercise for night nurses. They are apparently less inclined to make the effort than those on day shifts.

\* \* \*

The papers for registration examinations in Manitoba and Nova Scotia are included in this issue. The questions reflect the differences in the demands made on nurses 40 years ago and today. How would you answer these questions?

"A person is found unconscious, to what may the condition be due?"

"How would you decide that a patient was pregnant about the fifth month?"

"What are the symptoms of typhoid

hemorrhage? What is the result? What is the treatment?"

"Give full directions for making beef tea with exact reasons for each step."

\* \* \*

The attack rate of typhoid fever among nurses has been calculated to be from eight to twenty times as great as among the civilians living in the same community. By the use of vaccine the typhoid rate can be reduced at least 75 per cent. Inoculation should be compulsory for every nurse in all general hospitals.

\* \* \*

Myopia or short sight is rarely present at the beginning of school life but it gradually increases so that at the age of 16 almost half the children have some degree of myopia.

\* \* \*

Until the last few years the general age requirement for admission to training was 23. It is a grave question whether the admission of young, immature girls of 18 or 19 to hospital wards and to the heavy phys-

ical demands and the overwhelming responsibilities and anxieties of such work as inevitably awaits them there by day or by night, should be considered.

\* \* \*

A survey has shown that public health work is still in its infancy. A fifth of the communities make no provision for inspection of school children; over a fourth make no effort to educate in health matters; nearly three-fourths have no housing laws; over six-sevenths have no program against the venereal diseases; over a half have no proper organization to combat infant mortality; and less than a quarter have a coherent program for the control of tuberculosis.

\* \* \*

*Care of hypodermic needles* — Keep the needles in equal parts of almond oil and alcohol in wide-mouthed bottles.

## ONTARIO

The following are staff changes in the Ontario Public Health Services:

**Appointments** — *Jean Thomson* (Toronto Western Hosp., Univ. of Toronto gen. course) to the Lambton Health Unit. *Jean McLaren* (Royal Vic. Hosp., McGill Univ. Montreal) to the Porcupine H.U. *Henriette Ducharme* (St. Luc Hosp., Montreal, Univ. of Montreal) to the Prescott and Russell H.U. *Jessie Renton* (Stobhill Hospital, Glasgow, Scotland, U. of T. gen. course) to the Sault Ste. Marie B.H. *Ruby (Irvine) Graham* (Toronto Gen. Hosp. and U. of T. gen. course) to the Scarborough Township B.H. *Winnifred Crockett* (Health Visitor and Queen's Institute of District Nursing) to the Toronto Dept. of P.H. *Lyla (Groat) Kendall* (T.G.H., U. of T. gen. course) to the Welland and District H.U.

**Resignations** — *Lois (Leeson) McConnell* from the Elgin-St. Thomas H.U. *June McKay* and *Florence (Sparling) Graham-Smith* from the Kent Co. H.U. *Ann Cowan* and *Catherine Murray* from the Lambton H.U. *Jean (Lloyd) Lorimer* and *Jean Sugg* from the Leeds and Grenville H.U. *Isabel (Taylor) Oliver* from the Middlesex Co. School Health Service. *Marilyn Bushnell*, *Violet (Sam) Joe*, *Beulah Mann* and *Gisele (Meloche) Mercantini* from the Ottawa B.H. *Mabel Bourne*, *Madeleine des Landes*, *Madonna (Hurtubise) Richer* from the Porcupine H.U. *Mary Harbic* and *Mary Sheller* from the Stormont, Dundas and Glengarry H.U.



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## It's not the Alcohol, it's the Toothpick

COCKTAIL PARTIES are more dangerous than you think. Mix alcohol, an upper denture, canapes and club sandwiches and the chances are that a potentially lethal weapon will be swallowed before the evening is over. A New York physician describes the common wooden toothpick — so commonly used in canapes and cocktails and to hold a club sandwich together — as a dangerous missile.

Though the human digestive tract seems capable of dealing with almost anything — people can swallow toys, shoe buckles and whole dentures and nothing happens — a toothpick is a different matter. It is extraordinarily dangerous because besides being long and sharp at both ends, indigestible and unable to turn corners, it is also invisible to x-rays. Once swallowed it has a fairly good chance of impaling some part of the digestive tract on its way through. No one is able to diagnose the trouble until the patient is on the operating table. People with upper dentures should be especially careful since the denture covers the part of the mouth most apt to pick up the pre-

sence of foreign objects. Alcohol can also anesthetize the oral mucosa.

— *New York State Journal of Medicine*

\* \* \*

Dramatic results are being achieved in the treatment of tension-produced pain through use of a new drug, Equanil. Tension headache, psychosomatic pain associated with gastric distress and other nervous disorders have all been successfully treated.

No evidence of habit formation nor drug tolerance has developed. An interesting feature is the lack of drowsiness the morning following the previous night's dosage. Long-time users have not required increased doses to gain effects but have even reduced the amounts. The drug has also been found useful in keeping alcoholics sober after withdrawal treatment and has much value in accomplishing withdrawal with a minimum of discomfort.

— *Bureau of Industrial Service (Canada) Ltd.*

# Fatigue Factor in Peptic Ulcers

FATIGUE MAY BE the key to a baffling aspect of one of man's commonest ailments, the peptic ulcer. Physicians have known for years that ulcers follow a seasonal pattern but they have never been able to decide on an exact reason. Now, a noted Scottish surgeon reports that there is a weekly, even a daily cycle in ulcer cases, and he believes the best explanation may be overwork.

Reporting in the *British Medical Journal* on a study made of more than 2,000,000 people, Dr. R. A. Jamieson, of the University of Glasgow, states that the pains and other symptoms of peptic ulcers increase on Friday and decline on Sunday. He also found that serious complications, such as internal bleeding and perforation of the walls of the stomach or duodenum, are more likely to occur late in the day when a person is tired than in the morning or during the night. Supporting the fatigue theory, Dr. Jamieson points out, is the fact that the highest incidence of perforation in western Scotland occurs in December when "many of the artisan class work overtime in the week or two before Christmas in order to earn extra wages to cover Christmas expenses." The lowest incidence, Dr. Jamieson notes, is during the month of July when Scots get more rest and recreation. The incidence begins to rise again in the fall and after the December peak maintains a fairly consistent level from January to July.

A slightly different pattern of seasonal incidence is reported by two U.S. doctors, R. S. Boles and M. P. Westerman, who made a five-year study in Philadelphia. They, too, found that ulcer incidence was lowest in the summer. However, they also report that incidence of stomach ulcers is highest from January to July while that of duodenal ulcers hits two peaks, one in March, the other in November. Most authorities agree that 85 per cent of all peptic ulcers are duodenal.

Fatigue also figures in a study made of English aircraft workers by Dr. J. A. Smiley. In a report of the Royal College of Physicians, Dr. Smiley pointed out that workers who have the most accidents "are far more liable to peptic ulceration than their fellows" and are absent more often for a variety of reasons including fatigue neurasthenia. However, Dr. Smiley inclines

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to the belief that emotional stress is responsible for the fatigue as well as the ulcers and accident proneness.

Although fatigue, stress, emotional disturbances and bad diet may be involved in the development of an ulcer, the single direct culprit is hydrochloric acid. When this acid is present in excessive quantities, far greater than those required to digest food, it tends to attack the lining of the stomach or the duodenum. The resulting open sore is the ulcer.

Medical scientists have developed a number of approaches to cope with excessive quantities of hydrochloric acid in the digestive system. Surgery or so-called anticholinergic drugs may be employed to act on the nerves that stimulate its secretion. However, such measures may be too radical. The more rational and widely accepted approach is treatment with antacid drugs. While some of these antacids may do more harm than good by causing "acid rebound" i.e. only more acid production, others such as Gelusil, effectively control excess acid, through direct neutralization and absorption, within the natural limits of stomach acidity.

— MEDICAL & PHARMACEUTICAL  
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\* \* \*

Le sage songe avant que de parler à ce qu'il doit dire; le fou parle et ensuite songe à ce qu'il a dit.

## News Notes

### ALBERTA

#### DISTRICT 2

##### PONOKA

Officers elected for 1956 are as follows: Mrs. E. Coombes, president; Mrs. L. Clapp, vice-president; E. Cook, secretary-treasurer; Miss E. Baker, representative to *The Canadian Nurse*. Guest speakers at recent meetings have been D. Percy, Chief Nursing Consultant to the Dept. of National Health and Welfare and Dr. Hutton, University Hospital, Edmonton.

#### DISTRICT 3

##### BANFF

The question of the chapter name was discussed at the January meeting. In line with the work done in other areas, proposed





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revisions of bylaws were studied and suggestions made. The importance of obtaining compulsory registration was once more emphasized.

#### CALGARY

The third meeting of the year was held at the Associate Clinic in January with 27 members present. Plans for a Bursary Tea in February are under the direction of D. Pechiulis.

The guest speaker was Mrs. Selby-Walker. She gave an interesting comparison of the nursing profession with teaching, secretarial work, dietetics and library science. Her first experiences as a probationer brought back many memories to all present.

#### HIGH RIVER

The annual meeting of the chapter had an attendance of 14 with Mrs. Goodwin presiding. An invitation has been extended to the nurses of Turner Valley to join this chapter following the disbanding of their own organization.

The following slate of officers will serve for the year: Mrs. K. Irving, pres.; Mrs. K. White, vice-pres.; Mrs. J. Dougherty, sec.; R. Sarsons, treas.

#### DISTRICT 8

##### TABER

At the last meeting of the chapter a nominating committee was selected to draw up a slate of officers for the coming year. A resume of proposed bylaw revisions was given by Miss Jorgensen. Nursing aides attended as honored guests on this occasion and participated in the Christmas program that followed the business session.

#### BRITISH COLUMBIA

##### PENTICTON

The slate of officers for the coming year is as follows: Mrs. A. Mason, president; Mrs. E. Rainbow, past president; Mrs. G. Hatson and Mrs. I. Browne, vice-presidents; Mrs. B. Wethered and S. Marak, secretaries; K. Leask, treasurer. The annual Valentine dance is to be held on board S.S. *Sicamous*. M. Delaney is in charge of arrangements.

##### TRAIL

The following slate of officers has been elected for this year: Mrs. Ross, pres.; Mrs.



## New Nursing Texts

### DRUGS IN CURRENT USE, 1956

Edited by **Walter Modell**, Associate Professor, Clinical Pharmacology, Cornell University Medical College. An alphabetical listing of drugs in common use, giving the principal characteristics of each, major uses, absorption, actions, administration, dosage, antidotes against poisoning, etc., 1956. \$2.25.

### THE USE OF DRUGS

By **Walter Modell**, and **Doris J. Place**, Instructor in Medical Nursing, Cornell University—New York Hospital School of Nursing. A textbook of pharmacology and therapeutics for nurses. The *materia medica* section has been greatly enlarged. Second edition, 1955. \$5.50.

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Wilson, 1st vice-pres.; Miss Caplette, corr. sec.; Mrs. Miller, rec. sec.; Mrs. Oxley, treas. The annual dinner meeting is to be held late in March at the Rossland High School.

Suggested new bylaws are to be studied by a committee under the leadership of Mrs. Morris, and presented to the members at a subsequent meeting. A report from the public health committee indicated that no further progress had been made in procuring polio vaccine. The appointment of Miss Oliver to the public health staff was announced. It was reported with regret that doctors' lectures had been discontinued due to poor attendance.

Following the business session, the film "Zinc Die Casting" was presented by Mr. Beinder of Cominco. He explained its connection with industry in Trail and provided the members with an excellent opportunity to see this facet of industrial life.

## VANCOUVER

### St. Paul's Hospital

The final report of the bazaar held late in December is a tale of both social and financial success. It is expected that there will be a clear profit of over \$600. The January meeting was both interesting and original. Dr. Gladys Cunningham who has spent many years in China was the guest speaker. Her topic was "Medical Experiences in the Orient." In keeping with the theme, the refreshments consisted of Chinese delicacies as well as American dishes. Graduates of other hospitals, presently on staff, attended as guests.

S. P. Kolehmainen and I. M. Konrad were the recipients of the silver trophies and orchid corsages offered by the association to the outstanding member of each division of the graduating class.

## MANITOBA

### BRANDON

Salk polio vaccine — its safety and effectiveness — was discussed by Dr. James T. Lunn, director of public health, as guest speaker of the Graduate Nurses' Association. Statistics and verifying statements all point to the advisability of polio vaccination programs. One million Canadian children received the injections without a single mishap. The greatest degree of immunity was achieved by giving two injections a month apart and a third, seven to twelve months later. Future plans for Canada's vaccine program are already well-advanced under the direction of the Department of National Health and Welfare. Members of the nursing profession were urged to be as influential as possible in educating the public regarding the advantages of polio vaccination. The care in preparation exercised by the Connaught Laboratories, Toronto has ensured a safe supply of vaccine for Canadian users.

Prenatal lectures are being sponsored by



the Health Unit of the city. Interested persons are to apply to the unit at City Hall. Dr. G. Coghlin, acting medical director of the sanatorium, was guest speaker at a subsequent meeting. He showed slides pertaining to his work which were enjoyed by all.

## WINNIPEG

### General Hospital

The library in the new nurses' residence, which will shortly be completed, is to be furnished by the members of the alumnae association as their project for the coming year. Plans have been made for a permanent office for the association in the present residence and a part-time stenographer has been appointed.

Graduates from other schools presently on staff have been extended a guest membership. They were welcomed at the annual Christmas meeting. The following officers have been elected for the coming year: J. Whiteford, president; Mrs. G. Kent, first vice-pres.; E. Henderson, recording sec.; Mrs. G. Maclean, corresponding sec.; A. C. Foster, treas.

## NEW BRUNSWICK

### EDMUNDSTON

"S.O.S. — Same Old Service" was the very original topic chosen by Sr. St. Joseph as the theme of her address at a recent chapter meeting. She stressed the patient-nurse relationship and the necessary qualities of good nurses. M. Archibald, provincial secretary-registrar, also participated in the program. She gave detailed information in regard to the new type of registration cards. B. Seamen who extended greetings from the national office of the V.O.N. was an honored guest. C. Pichette reported on the annual meeting held in Moncton.

The December meeting took the form of a Christmas party. C. Pichette was the hostess on this occasion. Several members canvassed for and assisted with the Red Cross blood donor clinic.

## ONTARIO

### DISTRICT 1

### CHATHAM

### Public General Hospital

In December, a cheque for \$1,092 was presented to Mr. Proctor Dick, chairman of the hospital board, as the final payment of the alumnae association's pledge to the building fund. The nurses of Chapter one, Blenheim, Ontario donated \$600 towards the \$5,000 pledge. The money has been used to completely furnish a case room in the new maternity wing. Officers elected for the year are: Mrs. G. Brisley, pres., Mrs. H. Reid, Miss Winnifred Fair, vice-pres.; M. Campbell, recording sec.; Mrs. G. Pritchard, corresponding sec.; Mrs. C. Wm. Case, treasurer.

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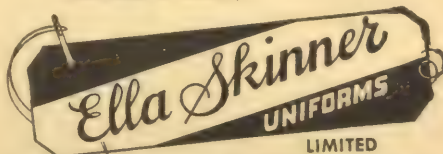
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## **DISTRICT 2**

### **WOODSTOCK**

A general meeting held at the new St. Paul's church was attended by 115 members. Canon J. H. Geoghagan, rector, gave the invocation. Mayor Bernadette Smith brought greetings from civic authorities and Dr. H. Baker extended a welcome from the Ontario Medical Association.

The guest speaker, Miss A. Reid, president of the R.N.A.O., outlined the historical development of nursing education. She stressed the self-sacrifice and toil which had been necessary to achieve present goals and which would be required in making further progress. I. Lawson, public relations secretary with the R.N.A.O., outlined the new bylaws for the members. Plans were made to send a delegate from the district to the biennial convention in Winnipeg.

Tom Patterson of the Stratford Shakespearean Festival was the guest speaker following the dinner. He spoke especially of the contribution that the festival has already made to Canadian culture.

## **DISTRICT 5**

### **TORONTO**

#### *Women's College Hospital*

The annual meeting and election of officers was held early in January. Late in the same month a January Nite was held at the Royal York Hotel with a drawing for a hope chest as a special feature. A student loan fund has been established as an alumnae project and members are being asked to contribute towards this.

## **PRINCE EDWARD ISLAND**

### **SUMMERSIDE**

#### *Prince County Hospital*

Miss Mildred Slackford has been appointed supervisor of the Old Prince County Hospital. This unit has been opened for the accommodation and care of patients with chronic illness, and is a division of the present general hospital.

## **QUEBEC**

### **SHERBROOKE**

A regular meeting of the English chapter was held in the Norton residence of the hospital in December. The students joined the members in viewing two very interesting films following the business session.

#### *Sherbrooke Hospital*

The annual fall dance of the alumnae association was held at the New Sherbrooke Hotel in November with a good attendance.

In December a choir of forty graduates and students carrying lighted candles, sang Christmas carols for the patients and then gathered in Norton residence with friends for a Christmas party. Graduates of 1954 and 1955 presented a very fine television set for use in the residence.

A Christmas tea and sale sponsored by the Students Council helped to swell the funds needed to send three students to the biennial convention in Winnipeg this year. H. Parnell was a recent visitor to the hospital.

## SASKATCHEWAN

### SASKATOON

The annual chapter banquet was held in December. A delicate arrangement of yellow mums and tall tapers formed the centrepiece for the head table. The banquet room itself was illuminated only by soft candlelight.

Miss Edith Shepperd, Centralized Teaching Program, introduced Miss Hazel Keeler, professor of nursing at the University of Saskatchewan, as guest speaker. Her interesting comments and movie reels of her recent trip to Europe were enjoyed by all.

### City Hospital

The student Nurses' Association with the graduate nursing staff held their annual Christmas party in mid-December in the Residence. During the evening Mr. and Mrs. J. E. Armstrong showed colored movie reels of recent events around the hospital, including graduation and capping. The highlight of the evening was the arrival of Santa Claus who presented gifts to many of those present.

### REGINA

In December of the past year Miss Myrtle Wilkins and Miss Lillian Lynch brought 27 years of service to a close with their retirement from the staff of the city health department. Miss Wilkins obtained her professional education at the Regina General Hospital. In 1928 she joined the immunization branch of the city health services. Miss Lynch is a graduate of the Winnipeg General Hospital. During the first World War she served in France and Belgium. In 1928 she, too, joined Regina's health staff serving first on the staff of the public school board before her transfer to the city health department.

In 1895, Charles D. Seeberger coined the word "escalator" to describe his moving stairway. The word was likely derived from the Latin word "scala" meaning ladder. In 1898 the first moving stairway was set up and when it was moved to France to be exhibited at the Paris Exhibition of 1900, it was labelled "escalator."

## VICTORIAN ORDER OF NURSES FOR CANADA...

requires

### PUBLIC HEALTH NURSES

for Staff and Supervisory positions in various parts of Canada.

Applications will be considered from Registered Nurses without Public Health training but with University entrance qualifications.

**SALARY, STATUS AND PROMOTIONS ARE DETERMINED IN RELATION TO THE QUALIFICATIONS OF THE APPLICANT.**

*Apply to:*

**Director in Chief,  
Victorian Order of Nurses  
for Canada,  
193 SPARKS STREET,  
Ottawa 4, Ont.**

## TEST POOL EXAMINATIONS FOR REGISTRATION OF NURSES IN NOVA SCOTIA

To take place on May 16, 17 and 18, 1956 at Halifax, Yarmouth, Amherst, Sydney and Antigonish. Requests for application forms should be made at once and forms **MUST BE** returned to the Registered Nurses' Association of Nova Scotia by April 16, 1956, together with:—

- (1) *Diploma of School of Nursing*
- (2) *Fee of Ten Dollars (\$10.00)*

No undergraduate may write unless he or she has passed successfully all final School of Nursing examinations and is within six (6) weeks of completion of the course of Nursing.

**NANCY H. WATSON, R.N. REGISTRAR  
THE REGISTERED NURSES' ASSOCIATION  
OF NOVA SCOTIA**

**301 BARRINGTON STREET, HALIFAX, N.S.**

# Calling All Canadian Graduate Nurses

- **How would you like to work and live in the heart of Manhattan?**

THE ROOSEVELT HOSPITAL, a voluntary, general hospital, offers you this opportunity.

- **Why not enjoy these benefits offered by Roosevelt?**

**BASE SALARY** — Begins at \$260 per month, without experience. Experience qualifies for higher starting salary.

**INCREMENTS** — Start after first 6 months and continue annually.

**BONUSES** — \$40 for evening and \$20 for night duty.

**VACATION** — 4 weeks annually.

**HOLIDAYS** — 10 annually.

**LAUNDRY SERVICE**

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**HEALTH SERVICE**

**SOCIAL SECURITY**

*For further information write to:*

**DIRECTOR OF NURSING,  
DEPARTMENT NS,  
ROOSEVELT HOSPITAL  
59th Street West,  
New York City**

## EDUCATIONAL DIRECTOR

for

**SCHOOL OF NURSING**

**Saint John General Hospital**

**DUTIES TO COMMENCE JULY 1, 1956.**

**Degree in nursing education with experience required.**

**New Educational Department  
opening in March, 1956.**

**Expected registration 200 students.**

**APPLY: DIRECTOR OF NURSING,  
SAINT JOHN GENERAL HOSPITAL,  
SAINT JOHN, N.B.**

## Know your China Better

The world is indebted to the Chinese for the origin of chinaware. Historical records show that it was produced extensively in China as early as 87 B.C. That explains the origin of the name "China". In Italy, it was called "porcelaine" because of its resemblance to porcellana, a lustrous sea shell.

Four fundamental raw materials are used today. First, china clay or kaolin, the original substance is used. In early times a large deposit of this material was found in China and was known to the Chinese as "Kaoling" meaning high hill. Hence kaolin today designates all pure clays which are white when burned . . . A smaller proportion of a more plastic clay, called ball clay, is added to facilitate the forming of the ware. Feldspar combines with the other substances and fuses together in the firing process. Quartz holds up the body structure of the china and gives it unusual strength.

— *Canadian Hospital*, FEBRUARY, 1955

The world's largest orthopedic hospital for children is operated by the Canadian Red Cross in Calgary.



# REGISTERED HOSPITAL NURSES, PUBLIC HEALTH NURSES

and

## Nursing Assistants or Practical Nurses

required for

### *Federal Indian Health Services*

#### **HOSPITAL POSITIONS**

Oshweken, Manitowaning, Moose Factory and Sioux Lookout, Ont.; Hodgson, Pine Falls and Norway House, Man.; Fort Qu'Appelle, North Battleford, Sask.; Edmonton, Hobbema, Gleichen, Cardston, Morley and Brocket, Alta.; Sardis, Prince Rupert and Nanaimo, B.C.

#### **PUBLIC HEALTH POSITIONS**

Outpost Nursing Stations, Health Centres and field positions in Provinces, Eastern Arctic, and North-West Territories.

#### **SALARIES**

- (1) Public Health Staff Nurses: up to \$3,300 per year depending upon qualifications and location.
  - (2) Hospital Staff Nurses: up to \$3,120 per year depending upon qualifications and location.
  - (3) Nursing Assistants or Practical Nurses: up to \$185 per month, depending upon qualifications.
- Room and board in hospitals — \$30 per month. Statutory holidays. Three weeks' annual leave with pay. Generous sick leave credits. Hospital-medical and superannuation plans available. Assistance may be provided to help cover cost of transportation.
  - Special compensatory leave for those posted to isolated areas.

*For interesting, challenging, satisfying work, apply to:*

Indian and Northern Health Services at one of the following addresses:

- (1) 4824 Fraser St., Vancouver 10, B.C.;
- (2) Charles Camshell Indian Hospital, Edmonton, Alberta;
- (3) 10 Travellers Building, Regina, Sask.;
- (4) 522 Dominion Public Building, Winnipeg, Manitoba;
- (5) Box 292, North Bay, Ontario;
- (6) 55 "B" St. Joseph Street, Quebec, P.Q.;
- (7) Moose Factory Indian Hospital, Moosonee, Ontario.

or

**Chief, Personnel Division,  
Department of National Health and Welfare,  
Ottawa, Ontario.**

# Positions Vacant

ADVERTISING RATES — \$5.00 for 3 lines or less; \$1.00 for each additional line.  
U.S.A. & Foreign — \$7.50 for 3 lines or less; \$1.50 for each additional line.

Closing date for copy and cancellations: 10th of the month preceding the month of publication. All letters should be addressed to: The Canadian Nurse, 1522 Sherbrooke St. W., Montreal 25, Que.

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**Director of Nursing & Nursing Education** for 160-bed General Hospital. Postgraduate course in administration or equivalent experience required. Salary open. Applications should give details of education, qualifications & experience. Apply Administrator, The Victoria Public Hospital, Fredericton, N.B.

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**Matron (Registered Nurse)** for private nursing home, please write Dr. Francis' Private Hospital, Ganges, B.C.

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**Supt. of Nurses** immediately for 67-bed hospital. Salary open depending on training & experience. **Gen. Duty Nurses** also required. Good salary & personnel policies. New 80-bed hospital opening in 1956. Apply M. M. Barber, R.N., Administrator, Portage Hospital, Dist. No. 18, Portage la Prairie, Manitoba.

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**Operating Room Supervisor** for operating suite — 4 rooms. 180-bed hospital. Good salary and personnel policies. Postgraduate course and experience preferred. Apply Miss B. A. Beattie, Director of Nursing, Public General Hospital, Chatham, Ont.

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**Operating Room Supervisor, Night Supervisor & Staff Nurses.** Good salary & personnel policies. Living accommodations available. Apply Director of Nurses, General Hospital, Parry Sound, Ontario.

---

**Psychiatric Nurse** to assume position as Head Nurse & Clinical Supervisor of new 38-bed Psychiatric Unit in a 500-bed General Hospital. An excellent opportunity for a Psychiatric Nurse who wishes to assume leadership in developing the policies, procedures & teaching program of this new Psychiatric Unit. Patients treated only by psychiatrists. The most modern facilities & treatment methods. Cooperative administration. Bachelor's Degree required plus Psychiatric experience. Salary commensurate with experience & abilities. Write Director of Nursing, Aultman Hospital, Canton, Ohio

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**Supervisor of Nursing** (Dept. of Public Health) to supervise the activities of a group of nurses engaged in a well-rounded public & school nursing & education program. Applicants should possess certificate in Public Health Nursing, a background of successful experience & supervisory ability. Current salary: \$295-\$315 per mo. Employee benefits include 5-day wk., 3 wk. vacation, sick leave, pension plan, etc. Forward detailed applications to Personnel Office, City Hall, Saskatoon, Saskatchewan.

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**Central Supply Room Supervisor** to organize & direct dept. in new 250-bed hospital. Experience in operating room &/or central supply desirable. Salary according to education & experience. Apply Supt., Children's Hospital, Winnipeg 4, Manitoba.

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**Obstetrical Supervisor (1)** preferably with postgraduate course, **Day Supervisor (1)** with experience, **Operating Room Scrub Nurse (1), General Duty Nurses (2)** for new 144-adult bed plus 32-bassinette hospital. Good salary & personnel policies. Apply Director of Nurses, Plummer Memorial Public Hospital, Sault Ste. Marie, Ont.

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**Obstetrical Supervisor (Experienced)** for night duty, 11-7. Salary: \$230 with board, room & laundry. Write to Director of Nurses, Misericordia Hospital, Haileybury, Ont.

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**General Supervisors, Operating Room Nurses and General Duty Nurses** for new 150-bed hospital. Starting salary for Registered General Duty Nurses \$230 with annual increases to \$40. 1½ days per mo. cumulative sick leave; 40-hr. wk; 28 days vacation; 10 statutory holidays. Apply: Supt. of Nurses, Trail-Tadanac Hospital, Trail, B.C.

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**Obstetrical Supervisor (experienced)** for modern, fully accredited 117-bed General Hospital with university-affiliated school of nursing. Postgraduate education desirable. Salary dependent on qualifications. Location 45 miles from Buffalo & Rochester. 40-hr. wk. Retirement plan. Educational aid. Apply Director of Nursing, Wyoming County Community Hospital, Warsaw, N.Y.



## EMPLOYMENT OPPORTUNITIES FOR GRADUATE NURSES

Due to the opening of a new wing in a well-equipped, new 125-bed hospital in Suburban Toronto. Enjoy the congenial working conditions of a smaller institution with the advantages of locating in metropolitan Toronto. Residence accommodation optional.

### SALARY RANGES

GENERAL DUTY \$205 - \$275 monthly

HEAD NURSES \$225 - \$295 monthly

SUPERVISORS \$240 - \$310 monthly

Apply:

DIRECTOR OF NURSING, HUMBER MEMORIAL HOSPITAL,  
200 CHURCH ST., WESTON, TORONTO, ONTARIO

**Operating Room Supervisor** for Ontario active surgical unit of 100-bed hospital. Approx. 1,800 cases annually. Vacation after 1 yr. of service. Sick leave, statutory holidays & Blue Cross Plan. Postgraduate diploma desirable but not necessary if experience is adequate. Apply The Director of Nursing, Cottage Hospital, Pembroke, Ont.

**Operating Room Supervisor (1) & Nursing Arts Instructor (1)** for 110-bed hospital. Apply Supt., The Charlotte County Hospital, St. Stephen, N.B.

**Assistant Evening Supervisor** for hospital with School of Nursing. Moving to new 250-bed hospital shortly. Apply Director of Nursing, Children's Hospital, Winnipeg 4, Man.

**Head Instructor for Training School to teach Sciences.** 86-bed hospital; 30 students. Complete maintenance provided in comfortable suite. Apply, stating qualifications & salary expected, A. J. Schmiedl, Sec. Manager, General Hospital, Dauphin, Man.

**Clinical or Nursing Arts Instructor** for university-affiliated school of nursing in modern hospital, pleasantly located 45 miles from Buffalo & Rochester. Starting salary: \$3,900. 40-hr. wk. Retirement plan. Apply Director, School of Nursing, Wyoming County Community Hospital, Warsaw, N.Y.

**Instructor** for school of nursing — Applications are invited for 138-bed hospital. This school is affiliated with Montreal hospitals, the teaching schools associated with McGill University. For particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

**Instructor** to teach anatomy and physiology, microbiology first term, followed by surgical nursing lectures and clinical supervision on surgical wards. Starting salary: \$255; \$10 for 2 yrs. experience; \$10 yearly increments; 1½ days sick leave, cumulative; 10 statutory holidays; 40-hr. wk; 1 class per yr. in September. Apply to: Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

**Obstetrical Clinical Instructor** for School of Nursing with capacity 195 students attached to expanding hospital of 571 beds. B.S. Degree in Nursing Education preferred or at least 3 yrs. experience & working towards degree. Located in "all American City" of 120,000 in North Eastern Ohio with educational, industrial, recreational & agricultural primary interests. Salary commensurate with qualifications. Write Director of Nursing, Aultman Hospital, Canton, Ohio.

**Nursing Arts Instructor** for School of Nursing, with capacity 195 students, attached to expanding hospital of 571 beds. B.S. Degree in Nursing Education preferred or at least 3 yrs. experience & working toward degree. Located in "All American City" of 120,000 in North Eastern Ohio with educational, industrial, recreational & agricultural primary interests. Salary commensurate with qualifications. Write Director of Nursing, Aultman Hospital, Canton, Ohio.

**Clinical Instructor (2)** for 222-bed hospital. Beautiful new nurses' residence combined with teaching unit. Present enrollment 57 students. For further information apply Director of Nursing, St. Joseph's General Hospital, Port Arthur, Ontario.

**Clinical Coordinator** to be responsible for rotation of student nurses. Applications to be made to The Director of Nursing, Miss Ida Johnson, Royal Alexandra Hospital, Edmonton, Alta.

**Assistant Head Nurses** for children's orthopedic hospital. Good personnel policies. Pension plan available. Apply Director, Shriner's Hospital for Crippled Children, 1529 Cedar Ave., Montreal.



# UNIVERSITY HOSPITAL

## SASKATOON, SASKATCHEWAN

### Requires

General Staff Nurses for Medical, Surgical, Obstetrical and Pediatric Services. Forty-four hour week. Salary \$210 to \$260 gross per month. Differential for evening and night duty. Residence Accommodation if desired.

Apply to:

DIRECTOR OF NURSING, UNIVERSITY HOSPITAL,  
SASKATOON, SASKATCHEWAN

**Assistant Head Nurses, Surgical, Obstetrical & General Duty Nurses** for 355-bed General Hospital. Starting salary: \$260, \$270 for afternoons & nights. Apply Director of Nursing Service, St. Vincent's Hospital, 2447 N.W. Westover, Portland 10, Oregon.

**Supervisor of Public Health Nursing** for generalized program in city of 43,000. 5-day wk., 1 mo. vacation with extra time at Christmas or Easter. Cumulative sick leave. Pension plan, Blue Cross & P.S.I., Workmen's Compensation. Transportation provided or allowance. For further information please write supplying details of training & experience to Dr. J. P. Wells, M.O.H., Peterborough, Ont.

**Supervisor & Public Health Nurses (qualified)** for Porcupine Health Unit, 5-day wk. 4 wk. vacation. 18 days sick leave annually. Car provided. Good working conditions. Apply Secretary, Porcupine Health Unit, 164 Algonquin Blvd. E., Timmins, Ont.

**Public Health Nurse Grade 1.** British Columbia Civil Service, Dept. of Health & Welfare. Starting Salary \$255, \$260, \$266 per mo., depending on experience, rising to \$298. per mo. Promotional opportunities available. Qualifications: Candidate must be eligible for registration in British Columbia & have completed a University degree or Certificate course in Public Health Nursing. (Successful candidates may be required to serve in any part of the Province.) Cars are provided. 5-day wk. in most districts. Uniform allowance. Candidates must be British subjects; preference is given to ex-service women. Application forms obtainable from all Government Agencies, the Civil Service Commission, 544 Michigan St., Victoria, or 411 Dunsmuir St., Vancouver 3, to be completed & returned to the Chairman, Civil Service Commission, Victoria. Further information may be obtained from the Director, Public Health Nursing, Dept. of Health & Welfare, Parliament Bldgs., Victoria, B.C.

**Public Health Nurses** with Certificate, permanent. Nurses with R.N. temporary for Polio Program. Apply Mr. J. Silvester, Personnel Officer, York Township Health Dept., 2700 Eglinton Ave. W., Toronto 9, Ont.

**Public Health Nurse** for the Peace River Health Unit. Duties to commence April 1/56. Salary in accordance with Provincial schedule. Apply Sec. Health Unit, Peace River, Alta.

**Public Health Nurses** for generalized program in Seaway Development Area. Minimum salary: \$2,700 with allowance for experience. Group insurance & Blue Cross available. Good transportation policy. Apply R. S. Peat, M.D., Medical Officer of Health, S. D. & G. Health Unit, 104 Second St. W., Cornwall, Ont.

**Registered Staff Nurses**, immediate appointments, in 511-bed newly enlarged and finely equipped general hospital. Duty assignments in medical, surgical, pediatrics, psychiatric, obstetrics, or contagion units. Northeastern Ohio stable "All-American City" of 120,000. In centre of area of recreational, industrial, and educational friendly activities. Living costs reasonable. Within pleasant driving-distance advantages of metropolitan Cleveland and Columbus, Ohio and Pittsburg, Pa. Friendly, cooperative work relations and conditions. Progressively advanced personnel policies. Starting salary: \$240 per mo. with 4 merit increases. Paid vacation, sick leave, recognized holidays, premium pay, sickness insurance and hospitalization program, retirement. Contact: Director of Personnel, Aultman Hospital, Canton, Ohio, by letter or collect telephone 4-5673.

**Registered Nurses for General Duty.** Initial salary: \$200 per mo.; with 6 or more months Psychiatric experience, \$210 per mo. Salary increase at end of 1 yr. 44-hr. wk.; 8 statutory holidays, annual vacation with pay. Living accommodation if desired. For further information apply Supt. of Nurses, Homewood Sanitarium, Guelph, Ont.

# ADMINISTRATIVE SUPERVISOR

Required by

## UNIVERSITY HOSPITAL

To organize a surgical unit of 100 beds. Good personnel policies.

Salary: \$240 to \$300 per month.

Apply to:

DIRECTOR OF NURSING, UNIVERSITY HOSPITAL,  
SASKATOON, SASKATCHEWAN

**Registered Graduate Nurses for General Duty** for 650-bed Tuberculosis Hospital, 10 mi. from downtown Toronto. Gross starting salary: \$93 bi-weekly, less \$15.23 for room, meals & laundry. 3 annual increments. 44-hr. wk., 8 hr. day, broken hrs. 3 wk. vacation after 1 yr., 9 statutory holidays. Hospital bus service to & from city. Apply Supt. of Nurses, Toronto Hospital, Weston, Ont.

**Registered or Graduate Nurses for General Duty (2)** for modern 20-bed hospital. Salary & increments in accordance with S.R.N.A. recommendations. 1 mo. vacation & sick time with pay after 1 yr. service. Separate staff residence. Apply Sec.-Man. Riverside Memorial Hospital, Turtleford, Sask.

**Registered Nurses (3)** immediately for 36-bed General Hospital in southern Manitoba. Starting salary: \$210 per mo. with 3 wk. vacation with pay 1st. yr. employment; 4-wk. vacation thereafter. All statutory holidays. Regular sick leave, 50%. Blue Cross payments. Apply Supt. of Nurses, Hospital Dist. No. 24, Box 330, Altona, Manitoba.

**Registered & Non-Registered Nurses, X-Ray & Lab. Technician** for General Hospital. Gross salary for nurses registered in Ont. equivalent to \$233.85 per mo. Good personnel policies, new facilities. 8-hr. rotating shifts; 44-hr. wk.; 1-day off 1 wk. & 2 the next. 1½ days holiday & sick leave per mo.; 8 legal holidays per year. Up to \$40 travelling expenses & increase paid after 1 yr. service. Semi-private Blue Cross with M.O.S. coverage. Full maintenance is provided including room, board & laundering of uniforms. Apply Supt., Lady Minto Hospital, Cochrane, Ont.

**Registered General Duty Nurses** for 18-bed hospital. Salary: \$240 less \$30 perquisites with yearly increase of \$10 per mo. 44-hr. wk. Vacation with pay, all statutory holidays, liberal sick leave. For further information please telephone collect to Miss H. Moore, Matron, Union Hospital, Oxbow, Sask.

**Registered Nurses.** Salary: \$225 per mo. gross. 5-day wk. Single room residence. 20 miles east of Toronto. Apply Supt., Ajax & Pickering General Hosp., Ajax, Ont.

**Registered Nurses (2)** for new 30-bed hospital. Apply Matron, Creston Valley Hospital, Creston, British Columbia.

**Registered Nurses** for Psychiatry. Student affiliation or postgraduate work preferred. For information apply Director of Nursing, Victoria Hospital, London, Ont.

**Registered Nurses** for 82-bed accredited hospital. Gross Salary: \$210-\$230 per mo. 44-hr. 5½-day wk. with no split shifts. 30 days vacation with pay after 1 yr. of service plus statutory holidays. Room in a comfortable residence & laundry of uniforms provided at \$10-\$12 per mo. Apply Supt. of Nurses, Union Hosp., Canora, Sask.

**Registered Nurses — General Staff, Operating Room, Psychiatric** for 300-bed General Hospital with new wing opening in April. Starting salary: \$220 per mo. with annual increment for 3 years. For further particulars apply Director of Nursing Services, Metropolitan General Hospital, Windsor, Ont.

**Graduate Registered Nurses** for general duty for 118-bed General Hospital along the shores of Lake Michigan, 25 mi. from Chicago. Base salary \$300. Good personal policies. Apply Highland Park Hosp., Foundation, 718 Glenview Ave., Highland Park, Ill.

**General Duty Nurses** for 40-bed hospital. Salary \$250, full maintenance \$45. 42-hr. wk., 28 days annual vacation plus 10 statutory holidays. Rotating shifts, cumulative sick leave, self-contained residence. Apply Director of Nursing, General Hospital, Princeton, B.C.



# University of Alberta Hospital

Edmonton, Alberta.

Requires General Duty Nurses. Salary range: \$190-\$215 per mo. plus 2 meals & laundry. 40-hr. wk. to be instituted not later than March 31st, 1956. Rotating shifts, 21 days vacation, statutory holidays, other benefits.

*For further information apply*

**ASSOC. DIRECTOR OF NURSING (SERVICE), UNIVERSITY OF ALBERTA HOSPITAL,  
EDMONTON, ALBERTA.**

**General Duty Registered Nurses & Certified Nursing Assistants** for 50-bed hospital. 44 hr. wk. For further information apply Supt. of Nurses, General Hospital, Cobourg, Ont.

**General Duty & Surgical Nurses** for 64-bed acute treatment, fully accredited hospital in Northern California. Excellent living conditions. Close proximity to vacation areas for leisure time. Full details at once on salaries, working conditions, paid holidays, paid vacations, paid sick leave & other benefits. Please apply Director of Nursing Services, Clinic Hospital, Woodland, California.

**General Duty Nurses** for 30-bed General Hospital. Excellent working conditions, personnel policies & recreational facilities. Apply Miss M. I. Baker, Supervisor of Nurses, Joyce Memorial Hospital, Shawinigan Falls, Que.

**General Duty Nurses** for 114-bed hospital. Salary: \$220-\$250 with \$5.00 increments every 6 mo. 44-hr. wk., 3-wk. annual vacation, statutory holidays etc. For further particulars please apply to Director of Nurses, Union Hosp., Swift Current, Sask.

**General Duty Nurses** for small hospital. Salary: \$200 per mo. plus maintenance. 8-hr. day, 44-hr. wk., statutory holidays as outlined by R.N.A.O. Travelling expenses refunded after 12 mo. service. New nurses' residence under construction. Apply Lady Minto Hospital, Chapleau, Ontario.

**General Duty Graduate Nurses** for well equipped 72-bed hospital on B.C. coast. Salary: \$222 per mo. less \$25 full maintenance. Semi-annual increments. 28 days vacation plus 10 statutory holidays after 1 yr. Apply Matron, St. George's Hospital, Alert Bay, B.C.

**General Duty Nurses for Medical, Surgical, Pediatrics, Obstetrics.** Good salary & personnel policies. Apply Director of Nursing, Victoria Hospital, London, Ont.

**General Duty Nurses** for all departments. Gross salary: \$210 per mo. if registered in Ontario \$200 per mo. until registration has been established. \$20 per mo. bonus for evening or night duty; annual increment of \$10 per mo. for 3 yrs. 44-hr. wk., 8 statutory holidays, 21 days vacation & 14 days leave for illness with pay after 1 yr. of employment. Apply: Director of Nursing, General Hospital, Oshawa, Ont.

**General Duty Nurse** for well equipped 80-bed General Hospital in beautiful inland valley adjacent Lake Kathryn. Boating, fishing, swimming, golfing, curling, skiing. Initial salary: \$240, full maintenance, \$40. 44-hr. wk. vacation with pay. Comfortable, attractive nurses' residence on grounds. Rail fare advanced if necessary, refunded following 1 yr. service. References required. Apply Bulkley Valley Dist. Hospital, Smithers, B.C.

## REGISTERED NURSES

**\$2,430 - \$3,120**

**ACCORDING TO QUALIFICATIONS**

*for*

**SUNNYBROOK HOSPITAL, TORONTO**

*and*

**WESTMINSTER HOSPITAL, LONDON**

Application forms, available at your nearest Civil Service Commission Office, National Employment Service & Post Office, should be forwarded to the Civil Service Commission, 25 St. Clair Ave., E., Toronto 7, Ontario.



## GRENFELL LABRADOR MEDICAL MISSION

The Grenfell Mission operates four Hospitals & seven Nursing Stations in northern Newfoundland & on the Labrador. Here is a wonderful opportunity for valuable experience & an adventurous life. If you are making plans for next year, why not consider this splendid service still carried on in the name of a great man?

*For full information please write*

MISS DOROTHY A. PLANT, SECRETARY, GRENFELL LABRADOR MEDICAL MISSION  
48 SPARKS ST., OTTAWA 4, ONTARIO

**General Duty Nurses.** Salary: \$230-270, \$10 increment for experience. 40-hr. wk. 1½ days sick leave per mo. cumulative; 10 statutory holidays, (1) mo. vacation. Must be eligible for B.C. registration. Apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

**General Duty Nurse (1)** immediately. Salary: \$220 per mo. less \$45 for full maintenance in new modern nurses' home. 40-hr. wk. 28 days vacation after 1 yr. service. 10 statutory holidays. Fare refunded after 1 yr. Apply V. H. Collins, Sec.-Treas., General Hospital, Golden, British Columbia.

**General Duty Nurses** for 165-bed Sanatorium. 44-hr. wk. 4-wk. vacation, statutory holidays. Apply Director of Nursing, Niagara Peninsula Sanatorium, St. Catharines, Ont.

**General Duty Nurses.** All shifts, no rotation. Starting salary \$290, increases to \$349 plus shift differential of \$10. Specialty services, **Ob-Peds-Tb-Isol** \$10-\$15 extra. 5 day wk. 3-wk. vacation end of 1st yr. 11 statutory holidays each yr. Nurses' home available at \$15 per mo. Ideal location, short distance from San Francisco or mountain resort areas. Apply Director of Nurses, Stanislaus County Hosp., 830 Scenic Drive, Modesto, California.

**Graduate Nurses** for 29-bed General Hospital — 2 positions open. Beginning salary: \$250 per mo. 2-wk. vacation with pay. Sick benefits, Blue Cross Hospitalization & Social Security Benefits. Apply Business Manager, Otis Hosp., Inc., 441 E. Market St., Celina, Ohio.

**Operating Room Supervisor.** Starting Salary: \$300 per mo., **Graduate Nurses** for 100-bed West Coast General Hospital. Salary: \$250 per mo. less \$40 for board, residence, laundry. 3 annual increments; \$10 per mo. night duty bonus. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. cumulative to 36 days. Transportation allowance up to \$60 refunded after 1 yr. Apply Director of Nursing, General Hospital, Prince Rupert, B.C.

**Graduate Nurses (3)** for 24-bed hospital. Salary: \$230 per mo. if B.C. registered; less \$40 board, lodging, laundry. 1 mo. vacation after 1 yr. on full pay. 1½ days sick leave per mo. cumulative. Apply, stating experience to Matron, Terrace & District Hospital, Terrace, British Columbia.

**Graduate Nurses (2)** for 64-bed hospital 250 mi. northwest Edmonton. Good train & mail service. Salary as recommended by R.N.A. of Alberta, increments of \$5.00 every 6 mo. for 2 yrs. \$30 room & board. Transportation allowance up to \$50 after 1 yr. service. 28 days paid vacation after 1 yr. plus 10 statutory holidays. 1½ days sick leave per mo. Apply Sr. Superior, Providence Hospital, High Prairie, Alta.

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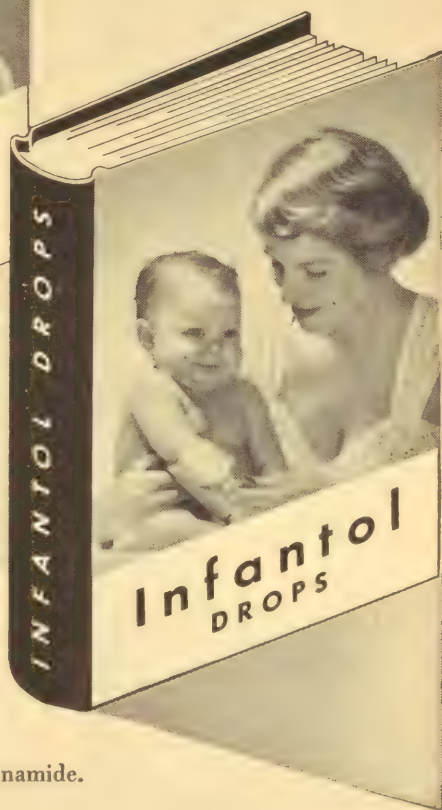
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# THE CANADIAN NURSE

## *L'Infirmière Canadienne*

VOLUME 52

NUMBER 4

APRIL 1956

- 246** NEW PRODUCTS
- 255** WHY ATTEND THE  
CNA CONVENTION? ..... *Sr. Theresa Carmel*
- 257** SASKATCHEWAN AND ITS PEOPLE ..... *Christian Smith*
- 262** FLUID BALANCE ..... *C. N. Partington*
- 263** THE ETHICAL RELIGIOUS NEEDS  
OF THE PATIENT ..... *Robert M. Frumkin*
- 264** IN MEMORIAM
- 266** BANDL'S RING ..... *P. Foster, A. McLeod, J. Palframan  
and D. Shouldice*
- 268** LE SERVICE SOCIAL ET LE CANCER ..... *Ghislaine Chamard*
- 271** ADVENTURES IN SCIENCE  
TEACHING ..... *Henrietta J. Alderson*
- 276** A VENTURE IN FIELD EXPERIENCE  
FOR GRADUATE NURSES ..... *Moyra Allen*
- 280** NURSING ACROSS THE NATION
- 281** LE NURSING À TRAVERS LE PAYS
- 284** TENTATIVE PROGRAM, 28TH BIENNIAL MEETING
- 288** REPORT OF THE ARRANGEMENT COMMITTEE
- 288** BOOK REVIEWS
- 298** SÉLECTION
- 299** NEWS NOTES
- 309** POSITIONS VACANT

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# Between Ourselves

Have you put a ring around the 1956 CNA convention dates on your calendar? That last week in June is going to be an interesting, invigorating and satisfying experience for the hundreds of nurses who join the trek to Winnipeg. Our guest editor this month, **Sister Theresa Carmel**, who is pediatric supervisor at St. Joseph's Hospital, Saint John, N.B. gives us some of the answers to the question "Why do nurses go to conventions?"

Very direct and convincing reasons are also contained in the tentative program that will be found on page 283. You were introduced last month to two of the guest speakers. Well known names of other prominent participants will convince you that you cannot afford to miss this outstanding event of the biennium.

\* \* \*

As everyone knows, the nurses of Saskatchewan and Manitoba are joint hostesses for the convention this year. **Christian Smith** has written the first of three stories that will appear in consecutive issues to acquaint you with the people, the progress and the promising destiny of these flourishing mid-western provinces. Next month Manitoba's story will be unfolded followed in June by a description of one of the friendliest cities on the continent — Winnipeg. Remembering that the convention dates coincide with the longest days in the year, we are looking forward with you to the glories of the sunsets, the long, lovely twilights, the pleasures that just being in Winnipeg will bring.

\* \* \*

Those of you who have read and received thoughtful encouragement from the articles that have been published in recent months discussing aspects of religion in the life of the nurse, will be pleased to learn that the second non-denominational conference for nurses is being held April 27-29 at Five Oaks Christian Workers Center near Paris, Ont. This conference is open to all nurses who are interested in learning how their personal lives may be enriched, how they may face their problems with a more realistic appreciation of their Christian stewardship. Sixty-five people can be accommodated overnight but last year the residence was filled to capacity so application must be made immediately.

\* \* \*

At the spring meeting of the Executive

Committee of the CNA, some time was devoted to the question of the present practice of holding special church services for nurses early in May each year. We were reminded that they were instituted originally as a memorial to our colleagues whose lives were lost in the wars in which our country has engaged. Their primary purpose was to give each of us an opportunity to rededicate ourselves to the service of humanity.

Somewhere along the road since the first such special church services were organized, some of the original intent seems to have been side-tracked by recurrent eulogies of the early founders of our profession. Perhaps the fault has been with the committees that have made the arrangements for the services with the clergy. Perhaps the proximity of the anniversary of the birth of Florence Nightingale to the date selected for the service has been a factor.

Let us, this year, place the emphasis where it belongs: If the nurses in each community, who are making the arrangements for the church services, will give their clergymen the definite theme: rededication, they will find him sympathetic and cooperative.

\* \* \*

Last month you read the interesting account of the way in which the new course for teachers of science subjects evolved at McMaster University. In this issue **Henrietta Alderson** gives us the inside story on how the new pattern of teaching has developed. Can you imagine *starting* your course in anatomy and physiology with a study of the central nervous system?

\* \* \*

Requests are received fairly frequently from schools of nursing for back issues that they require to complete certain year's copies for binding. As often as we can we fill these orders from our reserve supply. Periodically, we get requests for certain issues of which our supply is exhausted. Just now, we cannot fill the order received for the January and June, 1945 issues. Unless you are treasuring them, will some of you share these issues with these schools? Please send the copies to the Journal office: 1522 Sherbrooke St. West, Montreal 25, Que.

He who has not forgiven an enemy has not yet tasted one of the most sublime enjoyments of life.

— JOHANN K. LAVATER



## “Meat protein as well retained as milk protein...”

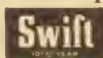
**E**VEN premature infants digested, utilized and retained the proteins and fat in specially prepared Meats for Babies according to Sisson, Emmel & Filer, “Meat in the Diet of Prematures”, *Pediatrics*, 7, 89 (1951).

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# New Products

Edited by DEAN F. N. HUGHES

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---

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**Manufacturer**—H. Powell Chemical Company Ltd., Toronto, Ont.

**Description**—Each tablet contains: Bone flour 0.5 gm. (Containing: Calcium 33.7%, phosphorus 15.16%, fluorine 0.05%), vitamin D 500 I.U.

**Indications**—For the prevention and correction of calcium and phosphorus deficiencies. Indicated in prenatal care, lactation, convalescence, malnutrition and as a dietary supplement for growing children.

**Administration**—3 to 6 tablets daily. Tablets may be chewed if desired.

---

## COROSERP

**Manufacturer**—Mowatt & Moore Limited, Montreal, Que.

**Description**—Each compressed and scored tablet contains: Corophyllin-N (hydroxy-ethyltheophylline) 100.0 mg., pentaerythritol tetranitrate 10.0 mg., rauserpen-alk. (reserpine) 0.25 mg.

**Indications**—For the symptomatic and prophylactic treatment of angina pectoris, especially where high blood pressure, anxiety and tension are important therapeutic considerations.

**Administration**—One tablet 3 to 4 times daily or as directed.

---

## DIAPARENE LOTION

**Manufacturer**—Homemakers' Products Corp., Toronto. Distributor—John A. Huston Co. Ltd., Toronto.

**Description**—Contains: Di isobutyl cresoxy ethoxy ethyl dimethyl benzyl ammonium chloride 0.067%.

**Indications**—A medicated lotion to eliminate and prevent ammonia dermatitis.

**Administration**—Apply at every diaper change and after bath.

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## DOLORUB

**Manufacturer**—Herd & Charton, Inc., Montreal.

**Description**—Powerful pain sedative containing 10% ethylene diamine salicylate, 1.25% methyl salicylate, camphor and chloroform.

**Indications**—Rheumatic, arthritic, muscular and neuralgic pains. Pulmonary and broncho-pulmonary action.

**Administration**—Apply ointment on affected area several times a day.

---

## ENTERBIOTIC TABLETS

**Manufacturer**—Pfizer Canada Division of Pfizer Corporation, Montreal 9, Que.

**Description**—Each tablet contains 50 mg. of terramycin and 250 mg. of neomycin sulfate.

**Indications**—For preoperative bowel sterilization.

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## EQUANIL

**Manufacturer**—John Wyeth & Brother (Canada) Ltd., Walkerville, Ont.

**Description**—Each scored tablet contains 400 mg. Equanil (2-Methyl-2-n-propyl-1, 3-propanediol dicarbamate) (Meprobamate), an anti-anxiety agent with muscle-relaxing properties, acting on the central nervous system.

**Indications**—Anxiety and tension states, neurological conditions where muscle spasm is a factor, muscle spasm due to rheumatic conditions, certain convulsive disorders.

**Administration**—One tablet (400 mg.) 3 times daily and, if indicated, one hour before retiring.

---

## RITALIN

**Manufacturer**—Ciba Company Limited, Montreal.

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**Indications**—Depression, apathy, anxiety states, discouragement, chronic fatigue, weakness, postpartum depression, depression after infectious illness, after effects of alcoholic abuse, convalescent or geriatric depressive psychoses and where the amphetamines are contraindicated.

**Administration**—Average dose is 5 to 10 mg. 2 to 3 times a day. This may be increased or decreased depending upon the individual response.

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#### TRIETHYLENE MELAMINE TABLETS

**Manufacturer**—Lederle Laboratories Division, North American Cyanamid Limited, Montreal, Que.

**Description**—2,4,6-tris-(ethylenimino)-S-triazine, an ethylenimine derivative. Its reactive groups are closely related to the nitrogen mustards. Grooved tablets 5 mg.

**Indications**—Similar to those for nitrogen mustard therapy. Indicated in the treatment of chronic lymphatic leukemia, leukolymphosarcoma, Hodgkin's disease and chronic myelogenous leukemia. Has advantages over nitrogen mustard in that it can be given by mouth. It causes only occasional nausea or vomiting. Patients can, in most cases, be treated adequately on an ambulatory basis.

**Administration**—Should be taken in the morning with plain water on an empty stomach. Food should be withheld for 1 hour afterwards, since the drug tends to be inactivated in an acid medium and is reactive with organic materials. The usual initial single dose of the drug is 2.5 mg. Some patients, especially those with chronic leukemia, may be especially sensitive and require not more than 1 or 2 mg. weekly. Complete blood count, including platelet estimation, should be taken weekly or more frequently for all patients receiving the drug.

**Caution**—Physicians should give the drug personally to the patients and should not dispense more than 1 week's supply at a time. This drug is highly toxic.

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#### UROSULFA

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**Description**—Each tablet contains: Sulfamethylthiadiazole 0.25 gm., sulfacetamide 0.25 gm.

**Indications**—For urinary tract infections, amenable to sulphonamides. This combination provides high solubility, prompt urinary levels and low acetylation.

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The Directress of Nurses, 343 West 50th Street, New York City 19

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# THE CANADIAN NURSE

## *L'Infirmière Canadienne*

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## Why Attend the CNA Convention?

**W**HY ATTEND the CNA Convention? Does that sound as if we were questioning the value of the national convention? Far from it! It is merely an invitation to weigh once more those values to be derived from membership in the CNA and attendance at the meetings.

As Canadians we have every reason to be proud of our heritage. We rejoice in the solidarity and the wholesome character of our nation. From union our country derives its strength. So too from union on a national basis our profession will be consolidated. It is not a question of attempting to fit all to one mould, but rather of gaining from the complex composition of our associations that richness of character that will make the Canadian contribution to our profession worthy of our Canadian ideals.

How is this to be accomplished? In these days with so many facilities for communication it is not difficult to disseminate ideas once they have been conceived, applied, and proven to be

of worth. For their initiation there is no greater stimulus than contact with other minds who, recognizing needs and intent on making progress, are ready to sacrifice, to venture, to give adequate leadership. That minds of such calibre be given opportunity to influence others through published articles and national conventions is one function of our national associations.

Where the seed may fall and fruit may be produced is not to be anticipated,



SR. THERESA CARMEL

Sister Theresa Carmel is Clinical Supervisor of Pediatrics at St. Joseph's Hospital, Saint John, N.B.

but whenever and wherever growth of new ideas is evident, the national association can arrange for, or even provide, facilities for research. At least it can offer a common ground where the discussion of possibilities may be examined from all angles and where discriminating minds may suggest, show up weaknesses, point out difficulties, emphasize possibilities and probabilities. Here the enrichment of any project may have its beginning. Here the recognition of the contributions of member associations, or those of the various fields of nursing may prove an incentive to others to take the initiative. Here provision for the solidarity of our progress is assured.

A strong national body is a safeguard for the profession. Through it, wrongs may be righted, rights maintained, and progress directed. The authority of the many is deferred to, and the voice of the national body prevails.

After these considerations do we need to ask why we should attend the CNA meeting? It is evident that such attendance will give us:

(1) A sense of belonging to a profes-

sion that is serving our Canadian nation according to our Canadian ideals, and pride in its accomplishments.

(2) A knowledge of new ideas of value that are focusing the attention of those who are studying the results of research in our field.

(3) Constructive criticism of the problems confronting us in our progress.

(4) Stimulation to rouse us to make our contribution to this progress and to consolidation of our profession in our individual spheres and through our association.

(5) Valuable contacts with those who serve in various capacities similar to our own. There are those who feel that as much is to be gained in these meetings as in formal assembly and that casual comparisons and contrasts are productive of great results.

(6) A broadening of our outlook with greater maturity and solidarity in our convictions and hence a greater power to influence and control.

Ordinarily we reap what we sow. We get from conventions in proportion to what we bring to them — old adages worthy of consideration.

## A Thought for Spring

### The Flower Growers Twenty-Third Psalm

The Lord is the grower of my flowers ;

I shall not want ;

He rests my tired muscles through the very color of his green lawns ;

He leads me, rested to the setting out of larkspur ;

He restoreth my soul while I plant columbine and phlox.

Though the shadow of despair fall upon my garden path,

I shall not fear.

Thou art with me in sunshine and in shadow ;

In my gardening tools I sense Thy comforting rod and Thy staff ;

Thou preparest a feast of beauty for me in the presence of a too mechanized world ;

From season to season my cup overflows

Its wealth of daffodils and tulips, of pansies and roses, of marigolds, delphinium, asters,  
chrysanthemums

Hold the balm of Thy goodness and of Thy mercy ;

Sharing Thy love and the flowers of the garden with others

I find myself already dwelling in Thy boundless and eternal gardens !

MARY DICKERSON BANGHAM

# Saskatchewan and Its People

CHRISTIAN SMITH

ONE DAY in Toronto a man telephoned the all-knowing T.T.C., which operates the trams and buses. He said: "My wife and I haven't seen a sunset since we left Saskatchewan. Can you tell us how to get to one?"

"Just a minute," said the girl who answered. A man came on the telephone. He was understanding and sympathetic.

"There's nothing to it," he assured the westerner. "Take a car going north on Yonge, get off at Lawrence Park, take a bus going east. Just tell the bus driver what you want and he'll let you off at the right place."

This once the T.T.C. was wrong. The Lawrence Park bus driver left the westerners off at a certain intersection. Darkness was settling in. In a few minutes the little expedition was smack up against the seven-foot brick wall of some bigwig's estate. It was evident that no sunset could be witnessed here and they returned home sadly.

Later, excursions out of Toronto led them to open country, limited sky-lines, and nothing in the way of the sunsets one experiences evening after evening in wide-open Saskatchewan. There they light up the whole horizon and high into the sky, a glorious blaze of color, which persists even after the sun has disappeared over the edge of the earth.

Nostalgia led the prairie folk back to the great flat prairie province, but it wasn't only the geography that tugged at their hearts. "It was also the climate," the man explained. "You can cope with cold weather, dry cold weather, such as we have in Saskatchewan. Provided there's no brisk wind, 35 below in Saskatchewan is pleasant compared with zero weather in Toronto or Vancouver. And it's infinitely better than the hot humid

weeks in summer when Toronto sweats under a leaden sky which seems like a hot, steaming blanket."

"Most of all, it's the people," his wife added. "Not that we found Toronto and other eastern places unfriendly. Canadians are Canadians anywhere. But westerners have a special quality of friendliness.

"And they have a way of getting things done," her husband went on. "That's why our boys and girls have no difficulty finding jobs when they go either east or west from the prairies."

Geography, climate, and people — Saskatchewan. But principally people!

One can get nostalgic for the long cool evenings and cooler nights, when it never really gets pitch dark, or for the crisp lovely mornings when the meadow larks sing their songs brilliantly for the motorist speeding by at 60 m.p.h.

One can have fond memories of the short winter afternoons, too, the quiet, cold Sunday afternoons, when the light fails early and there are long shadows on the snowdrifts.

There is longing, too, for the seemingly endless gravelled roads, straight as a bricklayer's plumbline, with distant elevators poking over the horizon to mark another little town. Not very good roads, really, but so very much the Saskatchewan for which the exile yearns.



*Woodcock's Falls, Saskatchewan.*

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Mr. Smith is Director of Health Education, Saskatchewan Department of Public Health.



Heaven knows why people live in so many of the little towns except for sheer necessity to earn a living. Or is it that they find there other satisfactions? What keeps a doctor in some shabby little place, a druggist, a nurse, teachers, merchants, and others? Water so often comes from wells. The plumbing generally is outdoors. Until just yesterday many of the towns had no electricity.

The answer is, of course, that it's people that make a community, and when it comes to people, the folks in Saskatchewan make up for all the shortcomings and crudities of the environment.

White people came to this part of Canada more than 200 years ago, attracted originally by the wealth in furs. Last year Saskatchewan celebrated its golden anniversary, marking 50 years of membership in the Canadian confederacy as a full-fledged province. But the footings and foundation of Saskatchewan were in place long before 1905. There is a tendency to regard Saskatchewan as one of the youngest of the provinces. Actually, the trading post of Cumberland House, today the site of an outpost hospital and of educational facilities for northern residents, was established by the Hudson's Bay Company in 1774. It is said that this was before there was a white person living in what is now Toronto!

The fur traders came on the scene early in the eighteenth century — daring, adventurous men representing rival interests, and competing for the furs the Indians harvested by the tens of thousands. The country was peopled by various Indian tribes — intelligent, friendly, proud. It was the Indians who often kept the white traders from perishing. There was plenty of food on the prairies, where the great buffalo herds roamed. There was little food in the chief fur country, the rocky north, where traders often lived through winter on fish and nothing else, unless some wandering Indians could be persuaded to hunt for them.

From the traders the Indians obtained weapons and tools, blankets and tobacco, and they also got rum and disease. The earliest of four devastating epidemics of smallpox occurred in 1734 and it was attributed variously to

English traders from Hudson Bay, Canadian traders from French Quebec, and to Indians who moved north from the Mississippi river system, where they had been in contact with white settlers.

Smallpox played havoc with the Indian people. The fourth of the epidemics, lasting from 1868 to 1870, was estimated to have killed some 2,500 people — Indians and whites. It was stopped with the help of vaccine brought in by the Hudson's Bay Company and strict quarantine measures introduced in 1870 by the Northwest Territorial Council appointed that year. The explorer Palliser, who traversed this country three times, noted on his final expedition in 1854 that smallpox was common among the Indians.

Tuberculosis, likewise given the Indian people by the invaders, appeared in three great epidemics and helped further to decimate the natives. What disease had not done, hunger helped to finish, when in 1882 the last of the great buffalo herds moved south never to return. Wanton slaughter at the instance of greedy white traders finished off the one staple supply of food, clothing and shelter on which the prairie people could depend.

Although our western Indians were not brutally dispossessed and exterminated in the way that so many of their brothers were in the south, the end results were similar: very few Indians were left. Only in recent years has an awakened national consciousness led to a rehabilitation of the Indian, and today his numbers are increasing.

Although increasing numbers of hardy settlers began to take up land in Saskatchewan earlier, it was not until after the Saskatchewan Rebellion of 1885 that the peopling of the province-to-be took on the nature of a rush. Settlers came from eastern Canada, from northern areas of the United States, and from the British Isles and every part of Europe.

It has been interesting to live through the period since the first generation immigrants arrived here until today when their sons and grandsons are in every way Canadian in outlook, feeling, and performances, accepting community responsibility, adorning the learned professions.

Among the immigrants were people



*Legislative Building, Regina, Saskatchewan.*

from the teeming industrial centres of the British Isles, peasants from Central Europe, Germans from town and farm, Doukhobors and Mennonites from European Russia, and folks from all the Scandinavian countries.

The central Europeans were different, and it was thought at first that they would never assimilate. But they did, nevertheless, through their sons and daughters. The last vestiges of feelings against them seemed to disappear during World War II when it was common to read that some squadron leader with the name of Kowalsky or Hrynk had gone down in flames to keep Canada free.

Today it is hard to find more Canadian, more loyal citizens than some of the sons and daughters of central European immigrants, loyal, that is, to the ideals and values which Canadians hold in common as a heritage from the two nations that originally settled this country. Loyal to the crown, too, as evidenced when the late King George VI and Queen Elizabeth visited Saskatchewan in 1939.

The people who settled Saskatchewan had before them a tremendous undertaking, fraught with hardships and disappointments. Without a dream

of what could be and faith in their own abilities to bring it about, these people could never have founded here in so short a time the modern society now existing.

Many an early pioneer lived in a sod hut until he could afford lumber for a frame dwelling. Life was primitive and hard in many ways. It is difficult to picture what it was like only a generation ago, when one realizes that today 30,000 of Saskatchewan's 112,018 farms, with a total cultivated acreage of 40 million, have electrical power.

As the people filled in the great rolling prairie, families became less isolated. Schools and churches became a necessity, and people had to be found or trained to preach and to teach. Such needs led to the founding of the University of Saskatchewan, only three years after this area became a province. Moreover, there are today 4,500 schools and 7,345 qualified active teachers.

Roads and communications were

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All photographs used in this article are through the courtesy of the Saskatchewan Government Photographic Services.





*Saskatchewan Air Ambulance over Regina.*

essential. Today there are some 120,000 system-owned telephones in the province. Indeed, the first automatic dial telephones in Canada were installed in Saskatoon in 1907. Saskatchewan still has a highway and market road problem, but today there is the longest highway system in the world, with 1,230 miles paved and 6,400 gravelled.

These roads were a marketing necessity, enabling the rural population to dispose of produce and buy necessities. Over these roads they travel to Saskatchewan's eight cities, 97 towns, 378 villages. Distances are a factor in the high ratio of motor vehicles. This last year there were more than 160,000 passenger cars and almost 80,000 farm trucks in the province.

All this is indicative of the tremendous development that has taken place in a relatively short time, in spite of the frustrations and delays of bad years. Mostly it has been made possible because Saskatchewan people are men and women of prompt action for the common good and with a highly developed sense of mutuality — a family feeling, as it were.

Out of this came Saskatchewan's

highly developed marketing and consumer cooperatives. Thirty years ago the farmers learned that there was strength in union and set up their marketing pools, with a present total membership of more than 300,000. A little later they began to organize consumer cooperatives, of which there are now 422 with 160,000 members. At the same time the people thought that the chartered banks were good as far as they went, but they wanted to own banks and control credit facilities; therefore they have set up 281 credit unions.

In the earlier years farmers were urged to diversify rather than depend solely on grain production. An interesting sideshow was the development of Saskatchewan's honey industry. Saskatchewan's white honey is highly popular in eastern Canada and in Europe. In 1955 the honey crop totalled 3,315,000 pounds.

Even a certain diversification in agriculture did not give the province the economic stability it needed. The remedies have come along lately in the exploitation of natural resources — minerals, such as natural sodium sul-



phate, potash, and uranium, and the spectacular growth of the oil and gas industry. Today there are about 5,000 oil wells under license and last October the average daily production was well over 40,000 barrels of crude oil.

It is interesting to observe how, along with all this growth, the health and vigor of the people have been maintained and improved. In the early days there were smallpox, typhoid, diphtheria to contend with, and the primitive environmental conditions which were conducive to the spread of epidemic diseases. All three diseases are virtually non-existent today. The early emphasis in public health work was on safe food, including milk, safe water, safe disposal of wastes.

Among the many fields in which Saskatchewan has given leadership is that of public health. The guiding principle has been to share one another's burdens for the common good. Out of this came the legislation to provide for the diagnosis and treatment of all tuberculosis patients at public expense, a step taken just as the great depression of the thirties settled down on the province. A year later there were the first steps toward treatment of cancer at public expense, which became an actuality in 1944.

In 1944, too, the care and treatment of the mentally ill and of the mentally retarded became a provincial responsibility, and early in 1945 the province undertook to pay all the medical, surgical, hospital, dental, and pharmaceutical bills of those least able to do so for themselves — the old age and blind pensioners and their dependents, widows and deserted families, or families of incapacitated breadwinners, the province's dependent children, and finally, indigents — then numbering 25,000, now close to 35,000.

In 1946 legislation enabled the erection of public health units, (known as health regions, probably because of their large areas) to include the necessary population. There are eight

such health regions serving 380,598 persons in an area totalling 75,574 square miles. Considering this development and the municipal health departments of Saskatoon and Regina, about half of the population now has fulltime modern public health service.

While instituting a program of hospital construction grants which have resulted in the province having the highest ratio of beds per 1,000 population on the continent, the province took steps to overcome the disadvantages of maldistribution of medical and hospital care by launching the first public air ambulance service in the world. This service which takes emergency patients to treatment facilities has so far carried more than 7,300 patients without a mishap.

On January 1, 1947, the Department of Public Health instituted its compulsory Hospital Services Plan, which removed the financial barrier faced by many people needing hospital care. It has been widely popular. One important effect has been the freeing of Saskatchewan hospitals from burdens of debt and deficit. Hospital financing has been stabilized.

There have been many other important health developments, the most notable of which has been the introduction of a rehabilitation program. This grew out of previously provided care for poliomyelitis patients with paralysis.

A noteworthy feature of all these developments, as in other areas of endeavor, has been the part taken by voluntary societies and individuals. In their efforts to overcome problems and give their children and themselves as much of the good life as they can, Saskatchewan people have a way of ignoring differences of politics, religion and other divisive conditions.

Saskatchewan's population is growing, its economy continues to expand and the future is as roseate as the famous sunsets.

\* \* \*

Animal and vegetable oils oxidize readily. Rags, waste, excelsior and similar materials containing as little as five per cent of some of these oils will ignite spontaneously under favorable conditions.

— *Safety News Letter*

\* \* \*

Anger is the most impotent passion that accompanies the mind of man; it effects nothing it goes about; and hurts the man who is possessed by it more than any other against whom it is directed.

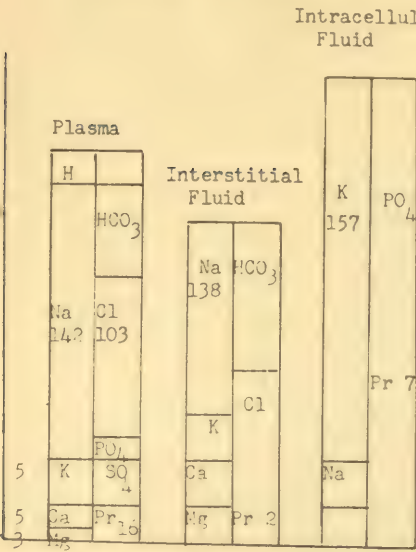
— CLARENDON

# Fluid Balance

C. N. PARTINGTON, M.D., C.H.B., M.R.C.S., L.R.C.P.

IN DISCUSSING the changes in fluid balance as it applies to the human body it is essential that we know the fundamentals of the various fluid systems. Furthermore, we must learn that all the constituents of the blood as a whole bear an intimate relationship one to another. Each mineral in the blood stream bears either a positive or negative charge and each set of minerals must balance — it is of the imbalance of these minerals that we are thinking today. In the following tabulation I have shown the value of both negative and positive charges for each of the minerals found in the body

Sodium	Na +
Potassium	K +
Chloride	Cl —
Bicarbonate	HCO <sub>3</sub> —
Protein	Pr —
Calcium	Ca + +
Magnesium	Mg + +
Phosphate	PO <sub>4</sub> — —
Sulphate	SO <sub>4</sub> — —



Milliequivalents per litre

The first sketch, labelled "Milliequivalents per litre," shows the equi-

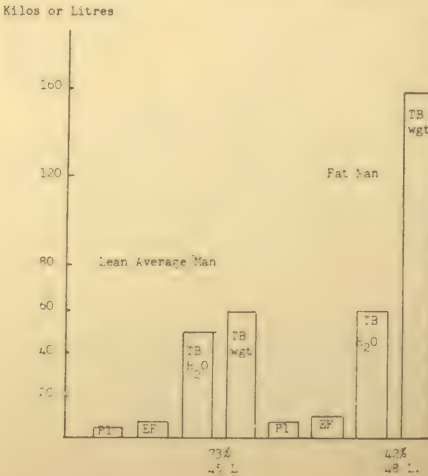
valents of the constituents of normal plasma, interstitial fluid and intracellular fluid. These three fluids are not at all similar as the diagram shows, and a 2 per cent difference in any one constituent makes a great difference to the individual — in the potassium balance of the intracellular fluid, for instance, 2 per cent of intracellular potassium loss in plasma would mean death! Milliequivalents are merely gauges by which all fluid constituents are compared — as we do in algebra — bringing various quantities to an x or y value.

The minimum fluid output requirements both in health and in disease varies considerably. Urine is of various specific gravities. It is important that all fluid output be measured accurately where fluid balance is to be maintained.

Minimum Output Necessary for 35 gms.

	Spec. Gr.	Vols.
Normal	1.032 - 1.029	473 cc.
Disease	1.019 - 1.015	605 cc.
	1.014 - 1.010	1439 cc.

As the blood travels back and forth to the heart, it is the pressure of the arterial flow that forces all the fluids and their mineral constituents — except the red blood cells and proteins — out of the arterioles and into the tissues. It is the osmotic power of the retained proteins in the venioles that draws back the excess and waste fluids



Dr. Partington is Director of Laboratory Services at Sarnia General Hospital.

out of the tissues and *into* the venioles whence they flow back to the heart, completing the circulation.

Now take a look at the second sketch where a scale of kilos or litres is shown. The first group of pillars represents an average lean man, the second group a fat man. Notice that the quantity of plasma and extracellular fluid are much the same regardless of the size of the patient, but the comparative H<sub>2</sub>O content of the two men is totally different. A lean man contains 43 litres of water which,

for his size, is 73 per cent of this whole fluid system, while a fat man, though his fluid content is 48 litres, it makes up only 42 per cent of the whole system. This shows the necessity of extremely careful adjustment in disease and also why no two people can be classed as similar fluid balance problems.

In burns, for instance, where much tissue is denuded of skin, the loss of fluids would mean a great deal more to a fat person because he has relatively less fluid to spare.

## The Ethical Religious Needs of the Patient

ROBERT M. FRUMKIN

**I**N EVERY CULTURE there is some higher power, whether it be a tree, a cow, a man, or some ethereal being usually called God, which is worshipped and through which man attempts to gain strength of mind, body and soul. This kind of religion represents religion in the *church* sense. There is also religion in another sense, a more universal sense. This kind of religion might be called religion in the *ethical* sense. The religious person in the ethical sense would be the *altruistic* person. This is the person who is beloved of his fellow men because he believes in and practises brotherhood, because he is unselfishly devoted to the interests of others. This kind of person is also the symbol of the perfect social being, of *Homo socius* a person who is supercooperative, who does always *more than* his share toward helping his fellow men. In short, the truly religious man in the ethical sense is the good man, in all languages and all cultures. Whereas the religion of the church is a religion of worship, the religion in the ethical sense is a religion of altruism.

The role of the nurse is essentially

a religious role in this sense, in the ethical sense; especially when this role is played with all one's heart, because then it is an altruistic and cooperative role. Florence Nightingale, Dorothea Dix, and Margaret Sanger are but three, among many, nurses who were supremely religious in this universal ethical sense.

When nurses are severely criticized by patients and their families it is not because they are felt to lack nursing skills, in the old sense with which we associate such skills, but because they lack this universal religious quality that every good and successful nurse must have. This religious quality in the nurse is shown in her genuine concern for the patient above all other interests when the nurse is ministering to the patient's needs. The patient is keenly aware of the presence or absence of this quality, for it shines warm and bright when it is there and manifests itself by darkness and coldness when it is absent.

The religious needs of the patient centre most in the need for this kind of religious experience and not for the religious experience that we associate with religion in the church sense. There is no greater strength of mind, body and soul a patient can gain than that which comes from a nurse, or any

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other person, who shows that he or she is genuinely and unselfishly concerned for his welfare and does everything in his or her power to see that the best can and is being done. Only when the nurse, or some other person acting in the capacity of a nurse, fails to provide this genuine need of the patient, does the church functionary — the minister, priest or rabbi — become indispensable. For now the fear of death looms large and only faith in a higher power, in God, with the aid of the church functionary, can bring some peace of mind, some peace and strength of soul.

Therefore, the religious needs of the patient centre in the need to be in fellowship with one or more human beings who have the patient's health and welfare uppermost in mind. When the nurse manifests this religious quality the patient feels that there is at least one person in the world to whom he means something, and upon whom he can count to help him.

When the patient lacks this faith in the nurse and his fellow-men, he then will most likely turn or return to religion in the church sense. For when everyone and everything else have failed, the higher power, God, can *always* be counted on, and God may be reached with or without the aid of the church functionary. It is here that faith in God takes over the unfinished task of the nurse. Of course, when the nurse (and the physician) has done all that could be done for the patient, faith in God is indispensable. Like medicine, praying to God, putting one's faith in God, can help to release and stimulate the healing powers of the body.

The patient, consequently, has two sources from which to seek spiritual strength — from the religious person in the ethical sense, or from God in the church sense. Both are important, and both supplement the work of each other.

## In Memoriam

**Loila (Marshall) Allison**, who graduated from the Ottawa Civic Hospital in 1928, died on September 25, 1955 after a long illness.

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**Annie Armstrong**, a retired nurse who resided in Penticton, B.C., died there on January 6, 1956 at the age of 70.

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**Anne Bradley**, who graduated from St. Michael's Hospital, Toronto, in 1901, died at Kingston, Ont., on December 25, 1955. After practising in the United States for many years, Miss Bradley joined the staff of the Royal Victoria Hospital, Montreal, in 1920. She retired in 1943.

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**Barbara Cecilia Day**, a graduate of a Calgary Hospital, was killed in an accident in Italy on December 23, 1955. She had worked in Leader, Sask., for two years prior to going to Europe.

\* \* \*

**Mary Ann (Haire) Garrett**, who graduated from the Sarnia General Hospital in 1903, died there on December 3, 1955 at the age of 77. At one time Mrs. Garrett was superintendent of nurses at S.G.H.

**Evelyn (Beatty) Hanna**, who graduated from Toronto General Hospital in 1907, died last winter.

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**Grace Margaret Hogg**, who graduated from Toronto General Hospital in 1923, died suddenly in England on November 30, 1955.

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**Laura Holland**, C.B.E., A.R.R.C., LL.D., who graduated from The Montreal General Hospital in 1914, died at Victoria on January 15, 1956 at the age of 72. Enlisting with the C.A.M.C. in 1915, Miss Holland was awarded the A.R.R.C. for her meritorious service in France and Salonika. Returned home, she qualified in social work then served as manager of the Welfare Division of the Toronto Department of Public Health. She moved to Vancouver in 1928 to reorganize the Children's Aid Society, becoming provincial superintendent of neglected children three years later. In 1934 she was made a Commander of the British Empire. Prior to her retirement in 1945 she became adviser to the minister of health and welfare. Miss Holland was regarded by all who knew her as a wise counsellor, an unselfish worker in the service of others,



LAURA HOLLAND

a warm friend and, to the end, a serene and gallant person.

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**Annie Jackson**, a graduate of a Cleveland hospital, died at Kitchener, Ont., where she had resided for the past 50 years, on December 29, 1955. She was 81 years of age.

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**Louisia Lagüe**, infirmière graduée de l'Hôtel-Dieu de Montréal, est décédée le 11 décembre, 1955. Graduée en 1921, elle fut à l'emploi de la Compagnie Assurance-Vie Métropolitaine. En 1923, elle entre à l'Assistance Maternelle et en 1924 se qualifia en diététique à l'Université de Montréal mais, son intérêt pour l'obstétrique la reprit et pour deux ans elle fut en service à l'Hôpital de la Miséricorde. L'Hôpital St-Luc lui confia en 1931, la fonction de diététicienne; elle resta à ce poste jusqu'en 1952, date de sa retraite.

\* \* \*

**Flora Liggett**, who graduated from Toronto General Hospital in 1909 died suddenly recently.

\* \* \*

**Elizabeth Jean Martin**, who graduated from Ontario Hospital, Kingston, in 1942 died on December 29, 1955, in her 35th year. Holding her degree in psychiatric nursing from Queen's University, Miss Martin had worked at Sunnybrook Hospital, Toronto,

Westminster Hospital, London and the Allan Memorial Institute, Montreal.

\* \* \*

**Myrtle McElroy**, who graduated from the Ottawa Civic Hospital in 1928, died suddenly on December 12, 1955. She had worked in the United States for the past 10 years.

\* \* \*

**Frances Milligan**, a graduate of a Buffalo, N.Y., hospital before the turn of the century, died at Toronto on December 31, 1955 following a brief illness. Over 90 years of age, Miss Milligan had returned to Toronto to live in 1924 when she retired from active nursing in the United States.

\* \* \*

**Barbara (Booth) Morrison**, formerly of Fort William, Ont., died at Portage la Prairie, Man., on January 10, 1956, a few months after she had retired.

\* \* \*

**Jean (Webster) Morrison**, who graduated from the Winnipeg General Hospital in 1904, died there on January 11, 1955 at the age of 88. Mrs. Morrison had been an active member of the alumnae association since 1907.

\* \* \*

**Lillian (Bolin) Probert**, who graduated from the Moose Jaw General Hospital in 1944, died there on December 27, 1955 at the age of 34.

\* \* \*

**Sister Jeanne d'Arc (Almida Theriault)**, who graduated in 1942 from Hotel-Dieu Hospital, St. Basile, N.B. died at Perth, N.B., in August, 1955.

\* \* \*

**Mary Natalie (McAulay) Taylor**, a graduate of Halifax Infirmary, was killed in an automobile collision on January 4, 1956.

\* \* \*

**Doretta Mae (Minchin) Traquair**, who graduated from Prince Edward Island Hospital, Charlottetown, in 1918, died at Moosomin, Sask., on November 8, 1955.

\* \* \*

**Hilda Willis**, who graduated from the Cottage Hospital, Pembroke, Ont., in 1940, died at Ottawa in January, 1955 following a lengthy illness. For some years she was employed in the radiology department of the Ottawa Civic Hospital.

Celui-là est le mieux servi, qui n'a pas besoin de mettre les mains des autres au bout de ses bras.

Ce qui fait qu'on n'est pas content de sa condition, c'est l'idée chimérique que l'on se forme du bonheur d'autrui.

# NURSING SERVICE

## Bandl's Ring

P. FOSTER, A. MCLEOD, J. PALFRAMAN and D. SHOULDICE

MRS. SMITH, a 20-year-old patient, appeared quite healthy and well nourished. She was a very pleasant and happy individual, married for three years to a well-built, healthy, happy chap who is a C.N.R. employee. Mrs. Smith has had an appendectomy done, a breast tumor removed. There is also history of rheumatic fever in 1943, and of an incomplete abortion with resulting dilatation and curettage in October, 1954. The complications of this pregnancy were: bronchitis, breech presentation of babe, Caesarean section due to Bandl's Ring, postoperative paralytic ileus.

The prenatal period was normal throughout. Labor began at home about 12:00 noon on September 27, 1955, with irregular contractions every 15-30 minutes that gradually became more frequent.

On admission to hospital at 4:25 p.m. contractions were every five minutes, fair in quality, lasting 20 seconds and causing no distress. The uterus appeared to be relaxing normally between contractions. The membranes were intact on admission — there was no evident "show". T.P.R. 98-80-20 and blood pressure 110/60. Fetal heart was 140 and good quality. Urinalysis showed a trace of albumin in a voided specimen. The patient was suffering from a coryza so was ordered on Wycillin 600,000 units daily and ephedrine nose drops q. 4 h. p.r.n. After twelve hours of non-progressive labor she was given Pitocin minims 1 for 2 doses, 2 hours apart. The contractions subsided, then started up

again irregularly at first, then every 5 minutes. They were fair in quality. The fetal heart varied within normal range 120-160, but was of good quality.

Another 12 hours passed with no satisfactory progress, so a consultant was called. On examination the fetus was found to be in breech position, right sacro-transverse, and engaged in the inlet. The fetal heart was on the right side lateral to the umbilicus but varied greatly as to both rate, rhythm and force — 170-180. A continuous induction of 500 cc. normal saline with 1.2 cc. Pitocin was started running at 30 drops per minute. A better labor was established with stronger and more frequent contractions. In spite of this improvement, satisfactory progress was still not being made.

On September 30, 1955, at 8:00 a.m. an x-ray of the pelvis was taken. It showed a pelvis within normal limits with some possible marginal disproportion of the brim. At 9:15 membranes were surgically ruptured in hopes of helping to speed up labor. The patient was found to be very tense, so Nisentil 60 mgm. was given p.r.n. as sedation. At 3:00 p.m. large quantities of meconium were passed and the cervix, by rectal examination, was thought to be fully dilated. At 9:00 p.m. Mrs. Smith was taken to the case room to be examined vaginally to determine the degree of dilatation and with the hope of breaking down the breech and terminating labor. The patient was found to be still very tense and the examination was unsatisfactory. A spinal anesthetic of 6 mgm. of Pontocaine and glucose was given and a vaginal examination carried out revealing the cervix almost completely out of the way. A hand, introduced

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This is another of the interesting clinics prepared by a group of nurses at the Sarnia General Hospital.



into the uterus to attempt to bring down a leg, ran into a strong contraction ring, or "Bandl's Ring," about the child's "middle." This ring was very firm and about the size of a fruit jar. Adrenalin was given in an attempt to relax it but to no avail.

During labor the uterus becomes differentiated into upper and lower segments. The part immediately above the internal os is weaker in structure than the rest of the uterus. As a result of the gradual retraction of muscles of the upper two-thirds, this part becomes progressively thinned out and is known as the lower uterine segment. This differentiation goes on throughout the first and second stages of labor, the upper segment becoming progressively smaller and thicker as a result of the contraction and retraction, while the lower segment becomes correspondingly larger and thinner as a result of the pull on it by the upper segment. Ultimately there is a clear line of demarcation between the two segments which is called the retraction ring or Bandl's Ring. In normal labor this is not so marked as to be recognizable clinically. When labor is obstructed this ring is inclined to contract around the baby causing fetal distress. If labor is allowed to go on, this ring can be seen on the abdomen as a ridge or depression above the symphysis. The higher it is the more serious the condition.

It was realized that a deep ether anesthetic, sufficient to paralyze the uterine muscles, would also injure an already damaged infant. It was therefore decided to do a Caesarean section. This was done immediately. A subumbilical midline incision was made and a baby boy delivered at 10:16 p.m. September 30. Ergometrine .25 mgm. was given intravenously at the time of delivery of the infant. Placenta and membranes were separated and removed and found to be complete. Whole blood 500 cc. was given intravenously. The uterus was closed with one layer of interrupted catgut sutures through the muscle and one continuous suture through the outer layers of muscle and peritoneum. Plain subcuticular and mattress silk sutures were used for the skin. The infant was slow to breathe but it seemed to respond fairly well following suctioning

of trachea and stomach of fluid and meconium and to administration of oxygen by mask. On leaving the operating room the babe's color was fairly good, respiration fair but rapid.

Mrs. Smith returned from the operating room in good condition: B.P. 110/80, pulse 80, respirations 20, with whole blood running intravenously. She was given Demerol 100 mgm. p.r.n. for operative discomfort. The first postoperative day and night passed with no significant happenings. She was allowed out of bed under supervision and appeared to be progressing well. She developed a productive cough that was troublesome. On the second postoperative night she developed a badly distended abdomen with elevation of T.P.R. — 102-120-30. She had some difficulty in breathing and her cough was troublesome. Following the removal of the catheter at this time she was unable to void.

A rectal tube was inserted in an attempt to relieve the distention but no result was obtained. She was given a series of two- 1-2-3 enemas and a soapsuds enema, in the next 12 hours. This did not relieve the distention although quantities of flatus were expelled. It seemed as though gas was forming as quickly as it was being relieved. Abdominal heat was applied with a rectal tube inserted and much relief was obtained.

A diagnosis of paralytic ileus was made. This is a serious form of obstruction in which intestinal peristalsis is inhibited by overactivity of the sympathetic nervous system. It may be seen in cases of generalized peritonitis or where there has been a great deal of handling of the abdominal organs in surgery, or following a hard, long labor.

On her third postoperative morning Mrs. Smith was able to void normally but her abdomen was again very hard and her breathing was distressed. At 2:30 in the afternoon she was placed in an oxygen tent to relieve her breathing and an intravenous of 1000 cc. 5% glucose in saline was started. She began to vomit small quantities of undigested food so a Levine tube was passed and Gomco suction established. An electrolyte balance was done by the laboratory director. Within the next 24 hours a marked improvement was

shown and gastric suction was discontinued. The abdomen was still somewhat distended but soft. On the fourth postoperative day the oxygen tent was removed. Mrs. Smith was given fluids by mouth which were retained. On the fifth postoperative day the intravenous was discontinued and the patient allowed out of bed. She had several liquid bowel movements which is typical of receding paralytic ileus. These subsided within 24 hours and Mrs. Smith then made a rapid recovery. Discharge from hospital followed on the tenth postoperative day with the patient feeling very well.

### THE BABY

On arrival in the nursery the baby's condition was poor — his color pale and cyanosed, his cry weak, respirations rapid and irregular. He was placed in an incubator with continuous oxygen, feet elevated to aid in mucous drainage. He was suctioned frequently. Weight was not recorded at this time because of his condition.

Because the Bandl's Ring had been around the breech-presenting child's legs and between the umbilicus and diaphragm, the chest was pushed up so that it protruded abnormally. The

abdomen was very flat with almost a concave appearance; the legs were flexed and flaccid. The skin appeared extremely dry and later there was considerable desquamation, possibly due to poor circulation.

October 1, the babe was weighed — six pounds eight ounces. Temperature at 8:00 a.m. 101.6. A pediatrician saw him at this time and ordered Aureomycin 12.5 mgm. q. 6 h. as a preventive measure because of the frequent suctioning; nothing by mouth for another 24 hours and continuous oxygen. The babe's color and respirations were improved and the temperature normal on the second day so lactose was offered q. 3 h. by bottle and taken quite well. Oxygen was discontinued the next day and the babe taken from the incubator. He was fed breast milk and complementary feeding until such time as his mother was able to nurse him.

He continued to improve, his body taking on a normal appearance. Weight gain was steady despite circumcision. He was discharged, weighing seven pounds one ounce, with the mother. A formula was provided as the mother did not have an adequate supply of breast milk.

## Le Service Social et le Cancer

GHISLAINE CHAMARD

EN JANVIER 1950, le Service Social Médical était fondé à l'Hôpital Notre-Dame, grâce à la belle initiative de son directeur médical le Dr. Boutin.

En mars '51, à la demande du Dr. L. C. Simard, une travailleuse sociale était assignée à l'aide des patients cancéreux au même titre que les autres départements desservis déjà: la médecine, la neurochirurgie, la pédiatrie et plus tard la chirurgie et l'otolaryngologie.

L'origine du service social médical remonte à 1905. Il est l'oeuvre de l'éminent médecin américain, le Dr.

Cabot du Massachussetts General Hospital à Boston. Il fut le premier à vouloir s'adjoindre une travailleuse sociale dans le traitement médical des patients. Le service social médical, c'est le service social appliqué dans un milieu hospitalier pour faciliter aux patients la meilleure utilisation possible des services existants de l'hôpital et si nécessaire de la communauté.

La formule du Service Social en général et celle du Service Social Médical ne s'opposent pas, elles concernent toutes deux des gens qui présentent des problèmes; la différence est en ce qu'au Service Social Médical, les personnes qui présentent des problèmes sont des personnes malades. Tous les

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services sociaux professionnels recherchent la même fin; le bien-être de la personne humaine. Une autre caractéristique du service social médical est qu'il fonctionne sur une base d'équipe dont le chef est le médecin.

La travailleuse sociale assignée au service des cancéreux fait partie de l'équipe de l'Institut du Cancer dirigé par le Dr. Simard et composé de médecins et d'infirmières. Cet Institut dirige des cliniques une fois par semaine où les cancers de toute nature sont dépistés et traités gratuitement. En plus du grand dévouement des médecins, il y a aussi ce dévouement des infirmières qui assurent le "follow-up" des cas, élaborent des statistiques précieuses à un centre de recherche.

Je puis dire que la travailleuse sociale d'une certaine façon fait partie de l'équipe médicale en assistant aux cliniques où elle discute des problèmes sociaux des patients déjà connus ou de nouveaux patients référés par le médecin. La travailleuse sociale rencontrera aussi les problèmes des patients que l'infirmière essaie de référer pour fins de contrôle ou de traitement et qui s'y refusent. Pour différentes raisons un patient peut résister aux convocations que lui adresse l'infirmière; soit qu'il n'ait pas l'argent nécessaire à son transport, soit qu'il craigne le diagnostic du médecin, et d'autres encore. Devant ces difficultés, la travailleuse sociale pourra organiser un transport soit par l'entremise de chauffeur bénévole ou en procurant au patient l'argent nécessaire à un billet de transport, dans d'autres cas, en interprétant le patient au médecin ou vice-versa.

Le Service Social Médical auprès des cancéreux s'effectue dans un climat psychologique spécial dû à la nature même du cancer: mal insidieux, mystérieux, redoutable.

Le cancéreux vit intérieurement un drame, il le vit seul la plupart du temps. Il ignore son état, il est référé très souvent à un stade avancé ou terminal de la maladie. Le cancéreux est exposé à l'aigreur, à la dépression morale. Son état chronique contre lequel la science ne peut rien parfois, lui suggère des sentiments de rejet ou de culpabilité s'il a trop retardé à voir le médecin.

Du point de vue de la travailleuse

sociale, le fait que le patient ignore son état présente des difficultés spéciales: le patient s'entretient dans un état d'illusion vis-à-vis sa guérison, il s'acharne au repos alors qu'il pourrait encore travailler un peu ou aider son entourage, il réclame la surveillance constante des médecins.

Parce que les cas sont souvent référés au service social à un stade avancé de la maladie, ils sont suivis par la travailleuse sociale jusqu'à leur décès. Disons que le service va au-delà du décès assez souvent, pour la réorganisation du foyer.

Énumérons maintenant les différents services que la travailleuse sociale est susceptible de rendre aux cancéreux. Ces services qui ne sont pas exclusifs aux cancéreux demandent dans leur cas une approche spéciale à cause des préjugés du patient. Combien de patients présentant une tumeur redoutent l'intervention chirurgicale parce qu'elle va "réveiller" le cancer. Il y aura donc comme services:

1. *Un support émotionnel* devant la crainte du traitement, de l'intervention chirurgicale.

Ce support émotionnel, la travailleuse sociale l'offre au patient dans une à plusieurs entrevues selon le cas. Il consiste en un lien de confiance que la travailleuse sociale établit avec le patient pour lui permettre d'exprimer ses anxiétés, ses difficultés, l'aider à les envisager et les solutionner. Ici donc entrent en jeu les techniques propres au service social personnel.

2. *L'interprétation* de ces mêmes traitements à la famille du patient qui peut ou bien renforcer, les préjugés du patient ou l'aider à les combattre.

3. *Le support moral* au patient qu'il faut préparer à envisager la mort.

4. *Le support* à la famille devant le pronostic fatal chez un de ses membres.

5. *Le placement en institution.*

6. *L'organisation des transports* soit pour la visite à la clinique ou pour les traitements de radiothérapie. Un patient peut avoir des traitements quotidiens pendant plusieurs semaines consécutives.

7. *Les soins à domicile:* ce sera des soins de propreté, l'administration d'injections de sédatifs contre les douleurs devenues intolérables. Quelquefois, la visite d'un médecin de l'hôpital quand le patient n'est plus en mesure d'être transporté.



8. *Les services d'une aide-domestique* pour permettre à la patiente d'assurer en même temps l'entretien de sa maison et la poursuite de son traitement médical. Ce service est plus indispensable quand la patiente en traitement trouve son gagne-pain dans la location de chambres qu'elle ne peut négliger si elle veut conserver ses chambres.

9. *La réhabilitation*: ce service laisse peut-être un peu sceptique quand il est confronté avec le diagnostic de cancer. En effet dans une grande proportion de cas, la réhabilitation consistera en une aide financière qui permettra de vivre convenablement jusqu'au terme fatal.

Ces besoins que la travailleuse sociale rencontre font appel aux ressources communautaires.

Je puis dire que la communauté répond généreusement à la détresse du cancéreux. Vous avez déjà songé à la Société Canadienne du Cancer, au Cancer Aid League et aux autres organisations sociales qui moins directement que celles déjà citées contribuent aussi au bien-être du patient. La Société Canadienne du Cancer rend des services sans lesquels il ne serait pas possible d'assister convenablement le cancéreux.

Cette société offre différents services grâce à l'initiative personnelle de la directrice des Services de bien-être. Elle a su s'adjoindre des auxiliaires clairvoyantes et dévouées pour la formation de services tels, le Centre d'information de la rue Papineau, le Service des pièces à pansement, le Service des chauffeurs bénévoles, etc. La Société Canadienne du Cancer répond financièrement aux besoins des transports, remèdes et diètes spéciales, elle supplémente des pensions en Nursing Home, aide du foyer.

Pour illustrer un peu l'efficacité des services rendus mentionnons en passant que le Service des pansements prépare et envoie des pansements à 550 patients par mois et qu'un même patient peut bénéficier de ce service gratuit au-delà d'un an et plus suivant

la durée de la maladie.

L'époque des Fêtes évoque encore le souvenir de Paniers de Noël à nos cancéreux indigents — une trentaine de patients cancéreux de l'hôpital Notre-Dame ont eu un Noël plus gai grâce à ces généreuses auxiliaires de la Société Canadienne du Cancer.

Le Cancer Aid League a récemment doté l'hôpital Notre-Dame d'un don de treize cents dollars généreusement mis à la disposition du patient cancéreux.

Une autre organisation sociale que je tiens à souligner pour ses services assidus et discrets, la Société des Infirmières Visiteuses. Par les soins de ses infirmières à domicile, la Société des Infirmières Visiteuses, assure le confort du patient, lui est en quelque sorte un prolongement de l'hôpital. Le patient qui quitte l'hôpital et doit continuer certains traitements, soit pansements, injections ou autre et tout rassuré si la travailleuse sociale lui promet la visite de l'infirmière visiteuse. Et qu'elles soient félicitées de leur diligence. Combien de familles n'auraient pas la même acceptation du patient cancéreux, alité, si elles n'avaient le support sympathique de l'infirmière visiteuse?

Je veux aussi mentionner l'ordre des Filles d'Isabelle qui par ses différents cercles offre des dons en argent utilisés à compléter l'achat d'articles indispensables nécessaires aux malades.

Voilà une énumération éloquente de services offerts aux cancéreux; je suis la première à m'en réjouir. Cependant, comme travailleuse sociale, je réalise de plus en plus à leur contact, que les patients cancéreux vivent des émotions qu'il est difficile de saisir. Si souvent, leur état d'âme nous échappe; nous ne pouvons nous tromper en leur témoignant une affection sincère.

Comme infirmières et travailleuses sociales, nos rôles sont différents auprès du patient mais se rejoignent puisse notre désir de l'aider nous unit et renforce notre effort.

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A simple, 90 per cent accurate blood test to help determine whether a patient has rheumatoid arthritis has been made available to physicians all over the country. This test is especially valuable in detecting the

disease in its early stages. It depends on the fact that sensitized sheep blood cells will clump when in contact with serum from a rheumatoid arthritis patient.

— *Scope Weekly*

# NURSING EDUCATION

## Adventures in Science Teaching

HENRIETTA J. ALDERSON, M.S.

THESE ADVENTURES had their beginning in a feeling of dissatisfaction on the part of the writer — dissatisfaction with the quality of the teaching being given in the sciences, basic to good nursing practice. Doubt was fostered by disinterest, indifference and low quality learning on the part of the students whose common complaint was "we don't see why we have to learn all that stuff." At McMaster, we have a problem not common to many schools of nursing, namely, that at least part of the teaching in basic sciences is divorced from nursing practice. The sciences (anatomy, physiology, microbiology, and introductory pathology) are taught in an integrated course during the first two years of university studies and, as such, are correlated with courses in the other science areas chiefly chemistry (inorganic, organic, and biochemistry). This means that during the first year the students have no contact at all with nursing practice; in the second year, contact is limited to one day per week during the academic term following a brief summer period at the end of the first year.

The problem simply stated was — "how can we make learning meaningful under these circumstances?" Fortunately, we are in a unique position, relatively free of traditional influences and with a wide measure of independence in planning and formulating teaching methods and experiences. Pondering on the question, common to some of the readers, we formulated three objectives toward which to work:

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Miss Alderson is a lecturer on the Nursing Faculty of McMaster University, Hamilton, Ontario.

(1) To improve the quality of meanings, moving progressively toward a fuller understanding for each individual and fostering self-maturity.

(2) To help the student see how the subject matter functions before she uses it, thus arousing in her a need for learning.

(3) To deviate from the traditional learning-centred curriculum, as one educator says "to unfix the ends."

An institute held at the university a year ago on the "case and incident method of teaching" stimulated thinking. Why could not cases and incidents be used in science teaching? As we thought of this idea we decided it had merit and could be used as a "spring-board" so to speak. We could not, however, use the terms or techniques in the strict sense of the word.

The method adopted, now in its second year of trial, is being constantly changed and altered from the original plan and we are daily finding new ways of developing and expanding its use. For clarity, the method as currently employed with our two groups of students will now be described in as much detail as possible:

### FIRST YEAR STUDENTS

For first year students, with little or no knowledge of nursing principles, we use incidents selected from within their experience field. Last fall, after an eight-week introductory period on a unit entitled "the cell, structural and functional unit of life," involving basic microbiological, cytological, histological and physiological principles, the students were ready to move forward to the larger unit "making adjustments to the external environ-



ment," involving the functioning of muscles, bones, joints, and nerves. As an introduction to the unit the students came to class prepared to discuss in as much detail as possible an incident involving "an experience with a frightening situation." An informal discussion ensued in which each student told "how she felt," "what she did" and "how she reacted" to the fear situation. The students were requested to note any feelings or reactions that they had in common with other members of their class. By the end of the presentation period, the following sensations or reactions had been recorded on the blackboard:

- loss of emotional control — including hysteria, excitement;
- loss of intellectual power — forgetting, repetition of words;
- loss of control — no sensation of what one was doing, running, collapse;
- feeling of coldness — whole body, hands shivering, cold clammy perspiration;
- other feelings — nausea, hollowness, dryness of mouth, muscles twitching, tension, shaking and weakness, fatigue, palpitation of heart, irregularity of pulse, increased rate, etc.

Progressing from these common feelings or reactions the students discussed the question — "In order to understand these feelings or reactions what do you need to know?" Many answers were forthcoming, such as —

*nervous system:* brain and spinal cord structure and function, memory, awareness, recall of past experiences, etc.

*organs of reception* — skin, ears, eyes, etc.

*basis of sensations:* coldness, shivering, dryness of mouth.

*organs of response:* heart and blood vessels, lungs — glands — adrenal — adrenalin.

*muscles:* contraction, relaxation, increased blood supply, oxygen, etc.

*bones, muscles and joints:* how they function together.

Then one student said "I'm lost, I don't know what we are doing!" The question was turned back to her classmates by asking — "How did you become aware of your fear?" "What did you do as a result?" "Why did you respond that way?" They reanalyzed their fear experience, noting — in answer to the questions —

(1) How they became aware of their

fear — what receptors functioned to make them aware of their environment.

(2) What they did as a result — they experienced the above-named sensations and/or carried out certain acts.

(3) Why they responded in that manner — the receptor received the stimulus, carried it to the nervous centre, which in turn sent out messages to mediate the response.

To make the relationship clearer one simple act was carried through, briefly, by the cooperative effort of students and teacher, step by step, from reception to response, to illustrate the possible pathway. The students now faced the decision of where to begin their study. With almost unanimous consent they decided to begin with the receptors — ear, eye, touch, etc.

All must agree that, in this case, any previously outlined knowledge objectives certainly became recast and variable. We began with material often considered so difficult by some instructors that they leave it to the very end of the course. The students and teacher managed the experience cooperatively, they found the area of need, located the trial centres (methods of approach) and decided the direction and plan of the work. The teacher of course, had to be willing to change some of the subject matter and to readjust some areas of previous teaching.

You may now ask "How is such an experience evaluated?" The use of an incident or experience is continued into the examination period. Following are some excerpts from the mid-year examination to illustrate the technique:

"Mary Jane, age 18 years, a pretty plump girl with brown hair and eyes, is attending university for the first time this fall. She wears glasses for reading. About mid-term while attending a chemistry lab. she cut the back of her hand rather badly with some broken glassware. She was given first aid by both the doctor and the nurse. For a few days all seemed well, then she noticed redness and swelling around the cut, accompanied by pain and tenderness. The doctor ordered her to hospital for treatment."

2. Mary wore glasses for reading, as she suffered from hyperopia.

(1) What is this condition? Describe the mechanism briefly.

(2) Mary's eyeball structurally consists



of several kinds of tissue. What is the function of each kind of tissue *italicized*?

- a. sclera — *white fibrous connective*
- b. ciliary body — *smooth muscle*
- c. lens capsule — *elastic connective*
- d. conjunctiva — *simple squamous epithelium*
- e. retina — *nervous tissue*
- f. tarsal plates — *white fibrocartilage*

(3) List the structures in order through which a ray of light would pass in order to reach Mary's retina. What is the function of each?

(4) Differentiate between the function of the rods and the cones.

3. *The following structures of the skin were injured by the cut.* What is the function of each?

- (1) stratum corneum
- (2) stratum granulosum
- (3) dermis
- (4) sebaceous glands
- (5) hair

6. *While in hospital receiving treatment Mary developed an infection of the respiratory system caused by a virus.*

- (1) What is a system?
- (2) What is the function of the respiratory system?

(3) What do you understand by each of the terms used in the definition of a virus — "a virus is an *ultramicroscopic, filtrable, intracellular parasite, producing inclusion bodies.*"

(4) During her infection all Mary's food seemed tasteless. Explain. Classify taste sensations.

Describe briefly the structure of a taste bud. How does it function? etc.

Your next question undoubtedly will be — "Where do you intend to go from this point?" The students have expressed unanimous desire and enthusiasm for their course of action — to proceed with the study of the brain and its mechanism. Following a brief introductory class in which an overview of the whole nervous system will be presented, the teacher and the students will again plan cooperatively to meet the immediate **problems** involved in studying this more **advanced** aspect of the original problem. Thus, learning becomes a series of need-experiences selected and developed through a circular learning process toward need-fulfillment, under the guidance of a mature adult who meanwhile is developing expertness in help-

ing them understand, accept, and use such a method.

## MORE ADVANCED STUDENTS

For more advanced students who have had some contact with actual nursing practice, case histories are used to good advantage. The histories are selected if possible from among the patients the students are nursing, preferably one that is familiar to several students. The histories should be real. They are used to introduce new units of work, stimulate informal group discussions or to provide settings for evaluation of learning. Before giving an example of this kind of planning, I would like to emphasize that only introductory pathology is taught and discussions do not involve theory or practice of any aspect of nursing. The unit on "body defense mechanisms" was introduced by a brief summary of three case histories, two of which follow, and the film "Body Defenses Against Disease."

*Case #1.* Mrs. King, age 31 years was first admitted to a general hospital on October 17, 1955. She was complaining of severe and intermittent pain of five weeks duration in her right upper quadrant. While in hospital, removal of her gallbladder resulted in disappearance of her pain. The pain recurred, however, within three weeks, with some evidence of relationship with food intake, and was accompanied by jaundice, nausea and vomiting.

She underwent surgery on October 23, 1955 for removal of a gallstone in the biliary duct. On October 30, 1955 there was redness around the incision with a drainage of yellow pus from the wound.

T.P.R. (ad) 98° - 84 - 20

October 30, 1955 - 101°

Culture report of drainage — *staphylococcus aureus hemolyticus*.

Sensitivity of organism — resistant to penicillin, moderately sensitive to streptomycin, highly sensitive to aureomycin, terramycin, chloromycetin, and erythromycin.

*Case # 2.* Mr. Hill, age 57 years, admitted September 16, 1955. History of right lower quadrant abscess with purulent drainage and some frank bleeding following operation three weeks ago. Area over right hip hot, red, and swollen.

T.P.R. (ad) 99.4° - 104 - 18. Area was incised and drained.

Laboratory reports —

	Pre-operatively	Post-operatively
Red blood count	3,680,000	4,280,000
White blood count	22,400	6,800
Polymorphs	97%	
Hemoglobin	68%	73%

Culture and sensitivity tests —

Coliform *bacillus* — highly sensitive to chloromycetin, resistant to all other antibiotics

*Streptococcus faecalis* — moderately sensitive to aureomycin, terramycin, chloromycetin and erythromycin.

Informal group discussion followed, stimulated by the question, "What do you need to understand in order to intelligently nurse these patients?" The teacher acted as recorder. By the end of the discussion period the following items had been listed on the blackboard:

- origin and properties — staphylococcus, colon *bacillus*, streptococcus *faecalis*
- resistance — patient vs organism
- antibiotics and sensitivity tests
- wound organisms — aerobic and anaerobic

- normal body flora — when does flora become pathogenic? What conditions predispose to this?

- signs and symptoms of infection

- reaction of the body to infection — general vs local

- defense mechanisms — including liver and spleen

- causes of disease — direct vs indirect (predisposing)

- antibiotics vs antibodies

- antibodies — chemical nature, duration, nature of activity, origin, kinds

- organisms — destruction, environmental needs, growth on media, morphology, pure vs mixed culture, pathogenesis

- how microorganisms are killed

- physical agents — heat, cold, light, drying

- chemical agents — antiseptics and disinfectants, sulpha drugs

- how microorganisms enter the body, how they spread within the body, how they leave the body

- how the environment is made safe — care of dressings, instruments, wounds, hands, dishes

- how microorganisms are transmitted.

Here it might be pointed out that it is sometimes helpful to analyze his-

tories under three headings:

- (1) Things we already know or understand.
- (2) Things we don't know or understand but know where to find the answers.
- (3) Things we don't know or understand and don't know where to find the answers.

This analysis of histories encourages the student since she identifies areas in which she feels confident, while pointing out her deficiencies. Following the analysis the group planned cooperatively as to where, when, and how they would meet their needs. In this case, some topics were noted to be covered by formal lecture presentation, some by laboratory experiences and others by informal group discussions. The students first decided where they wished to begin — with a lecture-discussion period on the "causes of disease, predisposing and direct." Further lecture periods dealt with the overall results of disease — the body's reaction to disease, passive, specific (local and general) and nonspecific (including the alarm reaction); the reparative process, local and general, including immunity and hypersensitivity, and the general principles underlying disease transmission, control and prevention. Informal group discussion dealt with topics already somewhat familiar to the students, e.g., defense mechanisms and antibody formation.

A reference list of suitable readings was made available to help in answering questions and to stimulate further thinking. Laboratory experiences included a study of wound pathogens (aerobic and anaerobic), sensitivity testing with antibiotics, determination of normal body flora, preparation of a bacterial vaccine, study of commercial preparations of vaccines and antisera, tests employed for the determination of antibodies in the blood sera, physical and chemical means of destruction and control and finally the study and evaluation of a nursing procedure involving either medical or surgical aseptic technique. It will be noted by many readers that in this study the case histories and resulting learning process involved somewhat more microbiology than physiology but this situation could well be reversed in the next problem the students attempt to solve.



What was achieved by these adventures? By these methods — either the incident or the case history — the students were stimulated to develop a "need". A need is defined as "some inner drive or force within an individual impelling him to the action observed by outsiders and indicating to them the nature of his learning."<sup>37</sup> The need arose out of the interaction of the student with the case history or the incident. It arose because she lacked experience to meet the situation provided, her previous experiences lacking quality, she must now find new and more satisfying experiences to solve the problem. The need will lead from present meanings to action, developing along the way inadequate answers, which in turn will stimulate new needs, demanding new experiences with better meanings and improved actions and finally a measure of self-maturity in an organized whole. Meanwhile everyone in the group has become more conscious of what, why, and how he selects meanings which are valuable enough to accept and retain.<sup>2</sup>

In conclusion may I say that this method has brought rich rewards both for students and teacher. For the student, it develops a goal for learning. She now learns because learning has taken on new meaning; she sees clearly the value and use of what she learns. Aspects of situations in which the individual makes no response can no longer exist, and in satisfying her need she extends the range and accuracy of her meanings. Furthermore, she develops ability in assessing a problem and planning a course of action in terms of desirable outcomes. She will be the better able to function as a mature individual when she is no longer under the direct guidance of her teachers. Finally she has learned to cooperate in group activities, to function as a member of a group, accepting a responsibility for group discussion and the outcomes of group action.

For the teacher, there is the reward of high quality learning. Students work harder and learn more than before; they pursue topics to a level of knowledge and understanding that you didn't believe possible. Discussions have spark

and enthusiasm because all participants are keenly interested and alive; there is no more dozing in class. Evaluation of previous learning and the avoidance of dull repetition is easier. Teaching is no longer stereotyped — lesson so and so on such and such a day — because you no longer know just what each session will bring forth. You are helping to develop personalities and to assist them in attaining new levels of maturity — students awoken and blossom under the experience. Discipline is no longer a problem and you shed the cloak of authoritarianism to become a member of the group, all of you working toward a common end.

But do not misunderstand! There will be moments when you wish you could go back to the safety of planned, detailed lessons. Certainly there will be misgivings and difficulties. The method is time-consuming and sometimes you will have to be satisfied with achieving less, but it will be of a higher calibre. You cannot arrange outside help — audiovisual aids, special lectures, supplies and materials as easily. You must be sufficiently prepared in your subject matter that you can meet the needs and questions of the group at all times or at least know where you can find a solution to the problems which arise. Meanwhile you will want to keep within the framework of the broad areas in your overall plan and maintain a measure of continuity, scope and balance. You must be prepared to develop well all the techniques and qualities of a good leader — a leader who is a better teacher because she has helped others to respect their experiences and themselves through application of all of the principles of good leadership.

I feel that we have just begun to explore this method as it applies to science teaching. We have much to learn, many difficulties to surmount and many moments of doubt ahead. However if, through the use of this method, we are able to raise the level of maturity of our students, to offer them greater opportunity to discover, release, and develop their potential capacities toward ever higher levels of self-enhancement, then we will be amply rewarded. For those who may wish to enter upon this adventure I



suggest that they may find help in successfully achieving their goal by consulting some of the references listed at the end of this article. To each adventurer — the best of luck and happy voyage!

1. Hopkins, L. Thomas, *The Emerging Self*. New York: Harpers and Bros., 1954.
2. Hopkins, L. Thomas, "Needs and In-

terests, A Sufficient Basis for the Elementary School Curriculum." *Schoolmen's Week Proceedings*, 1952 (Reprint).

3. Jersild, Arthur T., *In Search of Self*. New York: Bureau of Publications, Teachers' College, 1952.
4. Snygg, Donald and Combs, Arthur W., *Individual Behaviour*. New York: Harper and Bros., 1949.

## A Venture in Field Experience for Graduate Nurses

MOYRA ALLEN, M.A.

**I**N JUNE, 1955, the first year of a new course in teaching and ward management in medical-surgical nursing, was completed at the school for Graduate Nurses, McGill University, Montreal.

The field work was carried on in a 400-bed, general hospital with a small school of nursing. Two groups of graduate nurse students were involved, 20 students in the diploma program in medical-surgical nursing and four students in the final year of the degree program in nursing education and administration in hospitals and schools of nursing. The second group was responsible for the guidance and supervision of the first group, and the work of both groups was coordinated by members of the university staff. Considerable assistance, also, was received from the director of nursing of the hospital and her staff.

The field work was planned at every stage of development with both groups of students. As they could not all participate in each activity, the students selected projects in which they were interested. A rotation plan was set up so that each student would know her activities for the month and the time interval for each activity. Approximately one-half of the student's

time was devoted to projects in ward management and the other half to classroom teaching and clinical instruction. The first two days of the field work experience were spent in orientation to the hospital, the nursing service and the school of nursing.

### FIELD WORK IN WARD MANAGEMENT

During the one-month period it was not practical to expect students to administer or assist in the management of a ward; however, it was possible to analyze various aspects of ward management. The methods used should be valuable to the student in studying her own ward situation at a later date.

A "Head Nurse Study" was planned and carried out by all members of the diploma group under the guidance of one of the students in the final year of the degree program. The objectives of this study were:

1. To assess the level of the activities of the head nurse and the amount of time spent in activities at each level.
2. To determine the activities of the head nurse and the amount of time spent in each activity.

This was a time study in which the head nurse was observed continuously for a period of 16 days. The periods of observation were from 7:00 a.m. to 11:00 a.m. and from 11:00 a.m. to 3:00 p.m. Each student observed the head nurse for two consecutive pe-

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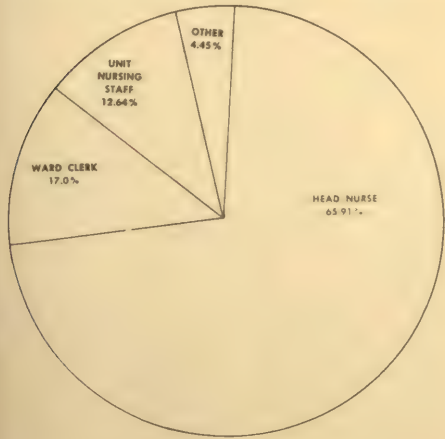
riods, one period one day and the second on the following day. The areas of activity and the levels of activity had been agreed upon prior to the study. The reliability of this study was probably decreased due to the difficulty of the students in judging the level of some of the activities of the head nurse. As all students observed the head nurse, another variable was added. Its influence on the findings was recognized but for the purpose of this study the emphasis was on method.

Table I shows the level of activity performed by the head nurse and the per cent distribution of time devoted to each level. It may be noted that 65.91% of the time was spent in activities considered to be of the head nurse level, while 17.0% was devoted to the ward clerk level and 12.64% to the unit nursing staff level.

TABLE I

*The Per Cent Distribution of Head Nurse Time by Level of Activity in One General Hospital in 1955.*

Level of Activity	Time in Per Cent
Head nurse	65.91%
Unit nursing staff	12.64%
Ward clerk	17.00%
Other levels	4.45%
	100.00%



*Figure I The Per Cent Distribution of Head Nurse Time by Level of Activity in One General Hospital in 1955.*

The remaining 4.45 was classified as other levels.

Table II shows the areas of activity and the proportion of time given to each area. Almost one-half of the head nurse's time (49.27%) was devoted to patient care, as compared with 16.80% devoted to ward administration and 10.41% to personnel administration. Personal and other time amounted to 23.52%.

TABLE II

*The Per Cent Distribution of Head Nurse Time by Area of Activity in One General Hospital in 1955.*

Area of Activity	Time in Per Cent
Patient care	49.27
Ward administration	16.80
Personnel administration	10.41
Personal	18.32*
Other	5.20
Total	100.00

\* Inclusive of lunch and coffee time.



*Figure II The Per Cent Distribution of Head Nurse Time by Area of Activity in One General Hospital in 1955.*

An "Analysis of Activities at the Patient's Bedside" was another study planned and carried out by the diploma students under the guidance of one of the students in the final year of the

TABLE III

*A Comparison of the Average Amount of Nursing Care Received per Patient with the Amount of Time Available per Patient from 7:00 A.M. to 3:00 P.M. on a Male and Female Ward in One General Hospital in 1955.*

Average Amount of Time in Minutes		
Ward	Nursing Care Received Per Patient	Nursing Care Available Per Patient*
Male	62.4	180.5
Female	66.9	176.7

\* Exclusive of lunch and coffee time.

degree program. The objectives of this study were:

1. To determine the amount of nursing care given a patient at the bedside.
2. To determine the time spent in the performance of each of six different areas of nursing care by each staff member at the bedside.
3. To compare the amount of time spent at the bedside with the amount of staff time available.
4. To determine the average length of each contact and the number of contacts per patient by each category of staff.

The method used was a spot study of observation units at fifteen-minute intervals, and included all the patients in two general medical-surgical wards. Areas of nursing care were classified under two headings — physical care and verbal interaction. Physical care included:

Routine nursing care — bed bath, back rub, making bed, arranging unit, taking temperature, giving or removing food tray, giving and removing bedpan.

Special nursing procedures or treatments — enema, catheterization, blood pressure, changing dressing, hot compresses, medications, giving injections, observation of postoperative patient.

Indirect activities — accompanying doctor on rounds, assisting doctor with treatments, taking patients to x-ray, bringing in mail or flowers to patient, taking equipment to or from bedside, checking clothing, having patient sign admission slip, charting at bedside, reading with patient.

Verbal interaction included:

*Procedural* — seeking, receiving, or

giving information concerning physical care, treatment or test.

*Personal* — greetings, joking, discussion of events in hospital or outside life, discussion of own or patient's feelings, recreational interests and skills, any friendly or personal conversation.

*Teaching* — specific information given by the nurse related to the patient's or his family's general health or specific health needs.

Table III shows a comparison of the average amount of nursing care received by each patient, male and female, with the amount of staff time available from 7:00 a.m. to 3:00 p.m. It is interesting to note that more than one-half of the available staff time is spent away from the bedside.

Table IV shows the analysis of this care given by the various categories of staff.

The average number of contacts of nursing staff with a patient from 7:00 a.m. to 3:00 p.m. on a male ward was 32.7, the average duration of each contact was 1.9 minutes. The average number of contacts on a female ward for the same period was 31.1, the duration of each contact was 2.1 minutes.

Further projects included an analysis of nurses' notes and morning report, an analysis of the method of recording doctor's orders and a study of the procedure for the administration of medications.

#### FIELD WORK TEACHING

Students in the final year of the



TABLE IV

*The Distribution of Average Minutes of Nursing Care Given by Each Category of Staff at the Patient's Bedside, Male and Female, from 7:00 A.M. to 3:00 P.M., in a General Hospital in 1955.*

Category of Staff	Average Amount of Time in Minutes	
	Male	Female
Head Nurse	1.0	2.0
Registered Nurse	22.0	33.1
Senior Student	13.9	5.8
Junior Student	11.8	13.5
Nursing Assistant	7.1	10.1
Maid	3.3	2.4
Orderly	3.3	—
Total	62.4	66.9

degree program supervised the students in clinical instruction in each of two medical-surgical units. Each supervisor was responsible for three graduate nurse students and each of these was responsible for one student nurse in the clinical instruction program. The activities in clinical instruction included:

1. Determining the objectives of clinical instruction in the unit.

2. Planning and carrying out an orientation program for new students.

3. Making out the student's assignments.

4. Guiding, supervising and assisting students to:

a) assess the needs of patients and to determine the nursing care to meet these needs,

b) make a nursing care plan for each patient,

c) organize the care of their patients,

d) give nursing care,

e) make a plan for patient teaching,

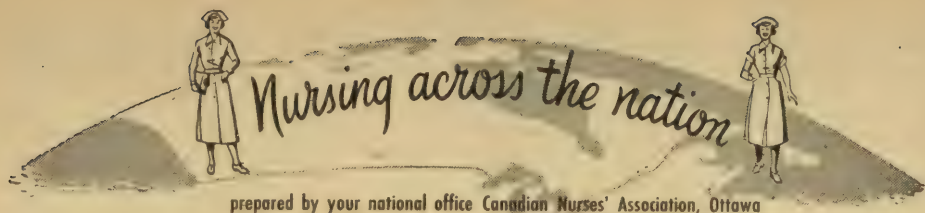
f) plan and give a nursing care conference,

g) evaluating the student's progress through observation, anecdotal notes, progress conferences and summary reports.

Each of the clinical instructors taught a class in medical-surgical nursing during this period and set test questions on the material that she had presented. As they were familiar with the patients in the wards, the teachers were able to take the students on nursing rounds to observe patients with conditions similar to those which they were studying. Similar projects in clinical instruction were carried on by one student in the operating room and two in the outpatient department.

In another study the students analyzed the learning experiences available for student nurses in the two medical-surgical units. It was both a quan-

(Please turn to page 292)



## *Meeting Place*

Ottawa was the centre of activity in February — nursing activity that is — as your CNA Executive Committee met for three days. Knowledge of the meetings was not confined to nursing circles alone, for due to constant press coverage, the citizens knew that they were hosts to 35 nursing leaders whose sole purpose here was to discuss and plan towards better nursing service for all Canadians.

## *What was Decided?*

In the realm of nursing service itself, approval was granted for the printing of an Orientation Manual. This will be ready for distribution in Winnipeg, at our general meeting in June 1956.

This manual, prepared both in French and English, is intended as a guide. It presents suggested plans for orientation in the major fields of nursing — hospital nursing (including private nursing), public health and occupational health nursing.

A statement of policies regarding nursing service, as prepared by the Committee on Nursing Service was approved. A combined pamphlet on nursing service and nursing education policies will be prepared and we expect it will be ready in June.

The report of the functions and activities of the head nurse continues to interest the CNA membership. It is hoped that further study may bring about recommendations concerning the functions and preparation of the head nurse.

## *More Study of Functions*

This time a study of the functions of the nursing assistant will be undertaken. The committee will be representative of both nursing service and

nursing education. When this has been completed, the provincial nursing education committees will be asked to review the curriculum for nursing assistants considering particularly the length of the course and educational qualifications for admission. A third step will then be to see that the basic nursing course provides student nurses with an understanding of the functions of nursing assistants and of their contribution to nursing service. Basic nursing students will thus be helped to assume the professional nurse's responsibility for the total nursing care of patients, including the care given by nursing assistants.

## *Accreditation*

This word, perhaps not so familiar to some nurses, will become, before the end of another biennium, a part of every nurse's vocabulary. To accredit, (according to Webster's dictionary), is to vouch for officially; to certify, as of a (prescribed or desirable) standard. It is agreed that it is the responsibility of any profession to evaluate its own programs of education. Accreditation, following such an evaluation, then, will benefit the health and welfare of the Canadian people since it will provide more effective nursing service through improving the preparation for that service.

A sub-committee has been set up to further consider this program of accreditation of schools of nursing. Dependent upon costs, a pilot study of accreditation in certain schools of nursing in Canada will likely be undertaken. Ample opportunity to study and consider such a program will be provided at the 28th Biennial Meeting.

## *Communications*

The Public Relations Guide prepared

during this biennium, having received executive approval, is ready to go to the printers. Copies in French and English will be available in June.

An amendment to the bylaws will be presented at the Biennial Meeting on behalf of the Committee on Publicity and Public Relations. It is suggested that the committee be called the Committee on Public Relations. This has arisen from consideration of the fact that publicity is but one of several "instruments" designed to promote public understanding and goodwill for the nursing profession within a total public relations program. So, come next June, CNA members will vote upon this amendment aimed to broaden the scope of this national committee.

General agreement was voiced by all executive members on the importance of keeping CNA members alerted to the new programs, developments and achievements in all spheres of nursing. A continuing stream of news covering committee activities is felt to be essential to the development of an informed CNA membership. What better place for this news to appear than in the pages

of *The Canadian Nurse*. Watch for this from now on.

### *CNA Crest*

Our present CNA crest is under revision. Samples of the proposed crest will be available at the Biennial Meeting. You the membership, will vote upon the crest of your choice.

### *International Nursing Service*

Executive members were reminded that it is the wish and hope of the International Council of Nurses, that nurses seeking employment or wishing observation of nursing programs in other countries be encouraged to use the services of their national nursing organization. It is interesting to note that some countries require that a "card of introduction" signifying sponsorship by their own national nursing association be used by the nurses. Such sponsorship for our nurses travelling abroad is assuredly of advantage to them. It not only gives them a feeling of security, but develops their knowledge and appreciation of their professional association.

## *Le Nursing à travers le pays*

### *Lieu de réunion*

Ottawa fut, en février, un centre d'activité en nursing; le Comité Exécutif de l'Association des Infirmières Canadiennes s'y est réuni et ces assises ont duré trois jours. Cet événement fut souligné par la presse et les citoyens canadiens ont appris que 35 infirmières, chefs de file de la profession, s'étaient réunies uniquement dans le but de discuter sur les moyens à prendre pour donner à tous les Canadiens un meilleur service d'infirmières.

### *Qu'a-t-on décidé?*

Dans le domaine du nursing proprement dit, la publication d'un Manuel d'Orientation fut approuvée. Ce manuel, rédigé en français et en anglais, sera distribué au Congrès de Winnipeg, en juin 1956, à titre de guide pour l'orientation dans les différents champs d'action de l'infirmière — nursing à l'hôpital, comprenant le service privé, service d'hygiène publique, etc.

Un travail préparé par le Comité du Service d'Infirmières, sur les lignes de conduite ou politique concernant ce groupe, fut approuvé. L'on combinera dans un même fascicule la ligne de conduite au sujet de l'éducation en nursing et celle du service de nursing. Nous prévoyons qu'il sera prêt pour le mois de juin.

Le rapport sur les fonctions et les tâches de l'infirmière-chef continue de susciter de l'intérêt chez les membres de l'A.I.C. Nous espérons qu'à la lumière de nouvelles études, des recommandations seront faites au sujet des fonctions et de la préparation de l'infirmière-chef.

### *Une autre étude*

Cette fois, l'étude portera sur les fonctions de l'auxiliaire en nursing. Le comité chargé de cette étude sera formé d'infirmières éducatrices et d'infirmières en service auprès des malades. Une fois ce travail terminé, les comités provinciaux de l'éducation en nurs-



ing seront appelés à reviser le programme d'études des auxiliaires en nursing, particulièrement en ce qui concerne la durée du cours et le degré d'instruction nécessaire à l'admission. Il sera alors à propos d'introduire au programme du cours de base dans les écoles d'infirmières des renseignements susceptibles de faire comprendre à l'étudiante infirmière le rôle de l'auxiliaire au soin des malades. L'étudiante-infirmière apprendra aussi comment assumer ses responsabilités d'infirmière professionnelle dans tous les soins donnés aux malades, même de ceux donnés par l'auxiliaire en nursing.

### **Accréditation**

Ce mot, qui ne revient peut-être pas souvent dans le langage des infirmières, fera avant longtemps partie de leur vocabulaire. Accréditer (d'après le dictionnaire Quillet) veut dire: faire connaître la renommée, la réputation d'une personne ou d'une chose; c'est la reconnaissance officielle de certains standards recommandés ou désirés. C'est un fait reconnu et incontestable qu'il est du devoir de chaque profession d'évaluer ses programmes d'éducation. L'accréditation, après une telle évaluation contribuera à l'amélioration du service d'infirmières. Le perfectionnement des moyens apportés à la préparation et à l'exécution du service du nursing assurera le bien-être de la nation.

Un sous-comité a été formé pour l'étude d'un programme d'accréditation des écoles d'infirmières. Selon les ressources dont nous disposons, une étude d'accréditation plus ou moins intensive sera faite dans certaines écoles d'infirmières du Canada. Vous aurez l'occasion, lors du 28ième Congrès biennal, de vous renseigner sur le programme d'accréditation.

### **Relations extérieures**

Le Guide sur les Relations Extérieures, préparé depuis le dernier congrès biennal et approuvé par le Comité Exécutif est prêt à être imprimé. Des exemplaires de cet ouvrage en français et en anglais seront à votre disposition en juin prochain.

Un amendement aux règlements sera proposé par le Comité de publicité et des relations extérieures. Il est suggéré que ce comité se nomme Comité des Relations extérieures, considérant que la publicité n'est qu'un des moyens dont nous disposons, dans un programme de relations extérieures bien organisé, pour renseigner le public sur l'activité de la profession d'infirmière et l'amener à mieux comprendre tous les avantages qu'il

peut en retirer. Ainsi, en juin prochain, les membres de l'A.I.C. seront appelés à voter sur cet amendement dont le but est d'étendre le champ d'activité du Comité National.

Tous les membres de l'exécutif furent d'accord sur l'importance de tenir les membres de l'A.I.C. au courant des nouveaux programmes, développements et accomplissements dans toutes les sphères de la profession d'infirmière; tous ces renseignements vous sont communiqués dans *L'Infirmière Canadienne*. Désormais soyez-en une fidèle lectrice.

### **Le Sceau de l'A.I.C.**

Nous sommes à reviser la composition du sceau actuel de l'A.I.C. Différents modèles vous seront présentés lors du Congrès Biennal et vous, les membres, serez appelés à voter pour l'adoption du sceau de votre choix.

### **Le Service International du Nursing**

Le Conseil International des Infirmières a rappelé au Comité Exécutif son désir et son espoir de voir utiliser le Service International du Nursing par toutes les infirmières qui désirent obtenir de l'emploi dans un autre pays que le leur ou qui désirent y faire un stage d'observation. Il est intéressant de noter que dans certains pays l'on exige que l'infirmière présente une "carte d'introduction" ce qui veut dire une recommandation de sa propre association nationale. Pour les infirmières voyageant outre-mer, la recommandation de l'Association Nationale offre de grands avantages, outre de donner à l'infirmière un sentiment de sécurité, elle lui apprend à connaître et à apprécier la valeur de son association nationale.

### **Chez les nôtres**

L'Assemblée Annuelle de l'A.I.C. aura un éclat particulier cette année. 1956 marque, en effet, le 10ième anniversaire de la sanction de la Loi des Infirmières du Québec. Pour la première fois, je crois, dans le monde, du moins en Amérique, la profession d'infirmière était légalement reconnue. Le Gouvernement de la province de Québec confiait aux infirmières, comme il l'avait fait jadis pour les médecins et pour les avocats, la lourde responsabilité, de l'administration d'une loi, responsabilité qui engageait tout l'avenir de notre profession.

Sous l'habile direction de ses dévouées présidentes et de ses secrétaires-registrières, l'on peut affirmer que l'Association a rempli consciencieusement sa tâche. L'Association compte actuellement plus de 10,000 membres

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Si nous regardons en arrière, nous constatons que de grands progrès ont été réalisés au cours des dernières années : progrès dans l'éducation, progrès dans le service des malades. La profession est mieux connue et plus

## Tentative Program

## 28th Biennial Meeting of the CNA

JUNE 25-29, 1956

Meeting of Executive Committee, CNA

Variety Concert ..... Winnipeg's Theatre Under the Stars



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Nurses often must devote much time to describing good nutritional practices.

"Meal Planning for the Sick and Convalescent" relieves you of the need for repeating over and over again essential dietary facts. This new Knox booklet presents the latest nutritional applications of proteins, vitamins and minerals, suggests ways to stimulate appetite and describes diets from clear liquid to full convalescent. It offers the homemaker for the first time detailed daily suggested menus for each type of diet, plus 14 pages of tested nourishing recipes.

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# SPECIAL SESSION FOR STUDENTS — TUESDAY

## MORNING

- "What the Future Holds" .....Panel Discussion  
(Participants will be student nurses).
- Question Period
- Buzz Session
- Luncheon for Students .....Lower Fort Garry
- Report from Buzz Session

(Student Nurses are requested to wear uniform for morning session.)

## AFTERNOON

- Group and individual activities

## Wednesday — June 27

## MORNING

### Nursing Service:

- "Toward Better Nursing" .....A dramatic presentation
- Discussion Period

## AFTERNOON

- Nursing Service .....Miss Alice Girard
- Guest Speaker .....Miss Margaret Arnstein,  
Chief, U.S. Division of Nursing  
Resources, U.S. Public Health Services
- General Discussion

## EVENING

- Guest Speaker .....Dr. Adelaide Sinclair,  
Executive Assistant to  
Deputy Minister of Welfare

## Thursday — June 28

## MORNING

- Nursing Education .....Miss Evelyn Mallory
- Panel — Accreditation, as it relates to preparation for Nursing Service.  
Participants to be announced

## AFTERNOON

- Discussion Groups
- Guest Speaker .....Miss Mildred Schwier

## EVENING

- Fashion Show

## Friday — June 29

## MORNING

- Trends in Health Services .....Miss Dorothy Percy, R.R.C.  
Chief Nursing Consultant, Department  
of National Health & Welfare
- Panel — "New Approaches to Civil Defence"  
Chairman — Miss Evelyn Pepper  
Dr. K. C. Charron, Director, Civil Defence Health Services, Dept. of National Health  
& Welfare  
Dr. J. S. Tyhurst, Assistant Professor of Psychiatry, McGill University  
Third speaker to be announced.

## AFTERNOON

- Report of Scrutineers
- Report of Student Nurses' Session
- Resolutions

## EVENING

- Mary Agnes Snively Memorial Lecture .....Byrne Hope Sanders, C.B.E.
- Installation of Officers
- Reception .....Hostesses — Alumnae Associations of  
Schools of Nursing in Winnipeg Area

# Report

from Carnation Research Laboratory



*Carnation Research Laboratory, 8015 Van Nuys Boulevard, Van Nuys, California*

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# Report of the Arrangements Committee

The Arrangements Committee reports the following progress to date in their planning for the biennial meeting.

**Accommodation** — Suitable accommodation has been arranged for a total of 1100 registrants. Special consideration is being given to provision of accommodation for members of nursing sisterhoods, student nurses and exhibitors.

**Transportation** — Cars and buses will be waiting at Winnipeg's railway stations, airport and bus depot on Sunday, June 24 to provide transportation to billets. Army cadets will be in attendance at the University residence to carry luggage.

Arrangements have been made to transport those staying in downtown hotels to the University campus each morning. Transportation for student nurse activities has also been arranged.

**General Information Sheet** — You will find one enclosed with the confirmation of your accommodation along with a city map.

**Special Activities** — A committee has been appointed to assist with plans for special group activities. A list of suitable restaurants and their price ranges has already been prepared for those planning an alumnae reunion, etc.

**Hospital Tours** — If you wish to visit any of the Winnipeg hospitals, arrangements will be made for you.

**Reception Committee** — Watch for the directive signs arranged for by this group to guide you to the University from the downtown area or about the campus itself.

Sunbonneted ladies of the "Covered Wagon" era will be ready to answer your questions at the Information Desk. And to help you recover that lost umbrella, our hostesses have thoughtfully provided a "Lost and Found" department.

**Name Tags** — Each registrant will receive a name tag.

**Committee on Entertainment** — Special church services have been arranged for Sunday evening, June 24. There will be a special Mass at St. Mary's Cathedral at 8 p. m. for Roman Catholics while the Protestant service will be held in Westminster United Church at 7 p.m.

Ethnic groups will provide the entertainment following the barbecue supper Monday evening, June 25. Tickets for the variety show and fashion show planned for subsequent evenings will be available at the Information Desk.

The sub-committee of transportation in charge of sightseeing tours has shown great initiative and imagination in their planning. You can be assured of seeing Winnipeg in a most enjoyable and novel manner.

We hope that all of you who have made even the most tentative plans to be among those present at this 28th biennium will find your hopes materializing. However, should you discover that you must cancel your arrangements, National Office would like you to know that the deadline for claiming a refund of your pre-registration fee is midnight, June 24.

## Book Reviews

**Human Relations in Nursing**, by Wayland J. Hayes, Ph. D., and Rena Gazaway, B.S. P.H.N., M.A. 471 pages. W. B. Saunders Co., West Washington Sq., Philadelphia 5, Penna. 1955. Price \$4.50.

*Reviewed by Dorothy Dick, School of Nursing, University of Manitoba, Winnipeg, Man.*

In this sociology text for basic nursing students a framework is provided to help the student understand the structure of society

and the social significance of the situations within which she works. The importance of the nurse being aware of how these concepts function in society is emphasized. She is then able to understand and to provide comprehensive nursing care for those whom she serves.

The book has two sections. Part I develops the sociological principles. It encourages the student to relate these to her own background and her present life as a nursing student. With this as a point of departure, the student is

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introduced to the broader aspects of society and the principles which underlie social organization. Part II applies the understandings developed in Part I to nursing situations. The first chapter of this section describes the growth and development of the social structure within which present day nursing functions. The second chapter outlines the sociological factors that are a part of every nursing situation. Attention must be given to these if comprehensive nursing care is to be achieved. A discussion regarding the influence of these factors on various nursing situations which arise throughout the life cycle concludes this unit. Bibliographies for additional reading and questions for further investigation and discussion are included at the end of each chapter.

If one accepts a need for a book which specifically relates sociological concepts to nursing, then this text would seem to perform that function. The concepts developed here, as they are put into action by nurses in their work with patients and families, will provide much of that understanding which forms a basis for comprehensive nursing care.

The title "Human Relations in Nursing" leads one to expect more emphasis on the interaction between individuals than is included. The emphasis has been put on the social groups and institutions of which the individual is a part, and their relationship to nursing and nursing care. The book would be a useful reference for any basic nursing student.

**The Meaning of Social Medicine**, by Iago Galdston, M.D. 137 pages. S. J. Reginald Saunders & Co. Ltd., Toronto 1, Ont. 1954. Price \$3.60.

*Reviewed by E. C. Shaw, City Health Dept., Calgary, Alta.*

Dr. Galdston's opening chapter illustrates very clearly that "Few among those occupied with social medicine agree entirely as to what it is. They do, however, agree that there is some such science in the making, and that whatever it may be and how much it may parallel or overlap public health and preventative medicine, social medicine is different from both." The failure of modern medicine "in the elimination of disease and in the promotion of health" is cited as the cause of the rise of social medicine. The author devotes considerable time to giving us the historical philosophies and background without which one would be completely at sea in following his train of thought.

In his chapter on mortality and morbidity, he illustrates how the gains in curative medi-

cine have produced new problems. The increase in care of the chronically ill patient, with its future high cost, is the result of the lack of interest by medicine in the common conditions of man and its emphasis on the uncommon. Dr. Galdston criticizes the clinical teaching of medicine. He suggests an experiment in teaching medicine in the gestalt of social medicine. In the addendum, one realizes that the discipline of social medicine is existent in the medical schools in England now. There is disagreement in the schools as to how "social medicine" is to be taught, but it is agreed that there is a "past, present and future for it."

The author, with his broad background in the fields of medical education, public health and psychiatry, challenges our present outlook on disease. He shows how a change in attitude and teaching can bring curative and preventive medicine together to promote health and eliminate disease. This book has been written primarily for the medical teacher/practitioner. It is also recommended for graduate nurses and senior staff members in both the institutional and public health fields.

**The Management of Acute Poliomyelitis**, by C. P. Stott, S.R.N., and M. Fischer-Williams, M.R.C.P. (Ed.). 99 pages. The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1955. Price \$2.15.

*Reviewed by Miss M. Blackwood, Nurse in Charge, Pediatric Dept., General Hospital, Hamilton, Ont.*

Since the world applauded the discovery of the Salk polio vaccine the public has hoped that polio has been conquered. The doctor and the nurse are aware, as a recent press bulletin states, that "polio is a world scourge growing more and more damaging with each passing decade." Eventually most nurses encounter the problem of nursing someone suffering from this dreaded illness and feel very inadequate in knowledge and experience.

Instead of the summary usually found in many types of nursing texts this book provides a ready reference outlining the disease and explaining practical points for the patient's care and comfort. It lists the equipment required and explains the value of physiotherapy in facilitating recovery.

The authors' keen appreciation of the polio patient's problems and their emphasis on principles of nursing should help a young nurse to understand the many aspects of the nursing care involved. Excellent use is made of pictures and diagrams. The mechanical equipment, which is unfamiliar to many nurses, is



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**Maritime Provinces:** C. M. Knowlton, 147 Granville Avenue, Halifax, Nova Scotia.

**Ontario and Manitoba:** Jack Hood School Supplies, 91 Erie Street, Stratford, Ontario.

**Quebec:** C. R. Senecal, 3288 Van Horne Avenue, Montreal, Quebec.

**Saskatchewan:** Commercial Printers, Ltd., 1935 Albert Street, Regina, Saskatchewan.



presented in simple terms and the details involved in nursing with it are handled thoroughly.

In reviewing this text book its practical qualities are very obvious. It is well printed on quality paper and is very easily read. It is

hoped that the title will not lead nurses to think of this book in terms of "poliomyelitis" only. It could improve the nursing care in so many illnesses that it well deserves a place on the reference shelves of the libraries of schools of nursing or in a nurse's personal library.

## Venture in Field Experience for Graduate Nurses

titative and qualitative study. The categories included the condition of patients, age group, acuteness or chronicity of the illness, nursing procedures and nursing problems.

All students were informed of the group's progress and difficulties in ward management and clinical instruction through half-hour conferences each day. At the completion of this field work two days were allowed for the presentation of reports and discussion of the results.

The consensus of the group was that this field work had been a most profitable experience. The strengths of this project were that it had been developed and planned *with* the students, that they had received guidance and supervision throughout the experience, and that time had been allotted for conferences regarding their progress and difficulties.

We are exceedingly grateful to the hospital for making this field work experiment possible.

In a recent experiment it was discovered that, during the course of her training, a student nurse walks 4690 $\frac{1}{4}$  miles.

La parfaite valeur est de faire sans témoins ce qu'on serait capable de faire devant tout le monde.

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the remarkable  
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gastrointestinal upset and malaise  
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One large group of infants suffered constipation, another group intestinal disturbances and malaise, coincident with teething.

The result from the studies were as follows . . .

**ALL CONSTIPATED BABIES** were relieved with complete easing of straining at stool, gas discomfort, restlessness and crankiness.

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constipation when present.

**EMINENTLY SAFE** — "Throughout the study . . . in no instance was there any untoward reaction; no cutaneous eruptions or other allergic manifestations, no petechiae, no rise in rectal temperature, no alteration in cardiac and respiratory function, no vomiting or diarrhea, no oliguria, no albuminuria. No significant changes were observed in weight, growth, development or hemoglobin before and after the period of medication."

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## In the Good Old Days

(*The Canadian Nurse* — APRIL, 1916)

His Majesty, King George V has been graciously pleased to confer the Decoration of the Royal Red Cross upon Miss M. C. Macdonald, Matron-in-Chief, Canadian Army Nursing Service.

\* \* \*

The distribution of the blood fluid in shock is of interest and may be arrived at by a process of exclusion. It is not in the arteries as they are contracted and blood pressure is low. It is not in the surface veins as these are collapsed. The fluid portion of the blood has not escaped from the vessels as edema is not a feature of shock and the specific gravity of the blood is not raised. There remain only the great veins of the splanchnic area where, I believe, the great bulk of the vital fluid will be found.

\* \* \*

Do not discard your old stockings! The tops of them make good petticoats or drawers for young children.

\* \* \*

A most efficacious method of preventing wound infection is to cleanse all the surrounding area with petrol before applying iodine. In a leg wound, for instance, wash from the groin to the toe nails.

\* \* \*

The infant welfare station established by Budin in Paris in 1892 and the milk depot opened two years later by Dufour mark the beginning of the modern movement for the reduction of infant mortality.

\* \* \*

Mrs. Nellie McClung, who was guest speaker at the monthly meeting of the Edmonton Association of Graduate Nurses, spoke of the work of nurses and advised them to meet as a club instead of being an organization. "Then you can work in perfect unison in all your efforts."

Though evidence is accumulating daily for the value of hypnosis as a therapeutic tool, its use has largely been limited to difficult childbirths and reclaiming amnesia victims and alcoholics. Now it has been used to stop a cough which had persisted for eight days and was precipitating the death of a 14-year-old girl. The patient had been admitted to the hospital with a deep, brassy, body-shaking cough which had failed to stop in 72 hours. Despite medication with

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Elastoplast bandages with Porous adhesive are now freely available. Prices are the same as the normal spread Elastoplast bandages.

## Points about Porous Elastoplast

1. Porosity throughout the entire surface of the adhesive — permits free evaporation of sweat.
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every cough suppressant in the hospital formulary, the patient continued to cough — and to fail.

With the patient dangerously near exhaustion, a hypnotic state was slowly induced suggestively setting up increasing time limits for the patient to suppress her cough. By the third day, she had the cough under control and was discharged from the hospital. It is almost certain that hypnosis saved her life.

— *New England Journal of Medicine*

\* \* \*

Approximately 80% of patients treated in Ontario general hospitals spent 10 days or less in hospital. Fewer men than women were in need of care, but on the average the men required one day more hospital care than the ladies. Respiratory diseases accounted for 14.02% of admissions. Treatment for fractured bones caused the longest periods of hospitalization with heart disease a close second. In the long-stay group there was a preponderance of older people — 75 years and over — although fewer individuals in this age range were admitted. Persons from 25-34 years of age required hospitalization most frequently.

— *Hospital Morbidity Study, Province of Ontario*

Faith is one of the forces by which men live and the total absence of it means collapse.

— WILLIAMS JAMES

## British Columbia

The following is a list of the staff changes in the Metropolitan Health Committee:

**Appointments** — *Mrs. Margaret Briar* (Toronto Gen. Hosp., Univ. of Toronto); *Nellie F. Davies* (Royal Free Hospital, London, Battersea Polytechnic, London); *Jessica Kirkland* (University College Hosp., London, Univ. of Edinburgh); *Mrs. Margaret Mead* (University Hospital, Edmonton, Univ. of Alta.); *Mrs. Margaret Papin* (Vancouver Gen. Hosp., U.B.C.); *J. Simons* (Grey Nuns' Hosp., Regina, U.B.C.); *Mrs. Gerda Todd* (Royal Vic. Hosp., Montreal, U.B.C.); *Norah White* (University Hosp., Edmonton, U. of A.).

**Resignations** — *H. Murdoch, M. Morgan, Mrs. Gardiner, E. Teir, Mrs. F. Clegg, Mrs. F. Whitelaw, Mrs. B. Revill, Mrs. M. Savage, Mrs. M. McKinnon.*





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## Sélection

*Comment vivent les Hommes en notre temps?*

M. Dickey Chapelle a publié un important article dans le *Saturday Evening Post* traitant de la "condition humaine en 1954" en dehors des groupes occidentaux et conclut:

1—Plus de gens vivent dans des huttes de boue et de paille que dans aucun autre genre d'abri.

2—Plus de gens voyagent sur leurs pieds ou sur le dos d'un bourriquot que de toute autre façon.

3—Plus de gens ont un espoir de vie qui n'est que la moitié de l'espoir de vie en moyenne aux U.S.A. que toute autre possibilité d'avenir.

4—Plus de gens vivent sans l'aide d'un médecin quand ils tombent malades qu'avec

une possibilité quelconque de soins médicaux même les plus rudimentaires.

5—Plus de gens mangent ce qu'ils ont pu faire pousser eux-mêmes et meurent de faim quand leur récolte est mauvaise que toute autre sorte de nourriture d'autre provenance.

6—Plus de gens ignorent ce que c'est que de voter que de gens qui le savent.

Les populations dites développées représentent 400 millions d'âmes, et l'ensemble de l'humanité comporte 2 milliards 500 millions d'individus. On se plaint qu'en France et dans certains pays évolués il y aura bientôt trop de médecins, mais en Ethiopie, par exemple, on compte un médecin par 100,000 habitants. "L'INFORMATION MÉDICALE ET PARAMÉDICALE"

Un acte n'est rien sur le moment. C'est un objet que vous jetez à la rivière. Mais il suit le cours de la rivière, il est encore là, au loin, bien au loin, toujours là; il traverse des pays et des pays; on le retrouve

quand on n'y pensait plus, et où on l'attendait le moins. Est-ce juste cette existence interminable des actes? Je pense que non. Mais cela est. — H. de MONTBERLANT  
(*La reine morte*)

# News Notes

## ALBERTA

### DISTRICT 3

#### CALGARY

##### *Crippled Children's Hospital*

"In tribute to those whose names are here recorded and to all others who through the years have given generously of their skill and devotion for the welfare of the little ones in the Alberta Red Cross Crippled Children's Hospital." A plaque bearing this inscription was recently unveiled in the hospital lobby to honor the medical and nursing staffs. The ceremony was performed by Mr. Ernest McLean, president of the Alberta division, and was attended by members of the provincial executive, Calgary Branch executive, the hospital board and many guests.

##### *General Hospital*

The Jessie Connal Memorial Scholarship Fund for presentation annually to a member of the graduating class was recently established. This has been just one of the numerous projects of the alumnae association during the past and current season. Other activities have included the sale of "hasti-notes," birth announcement cards and envelope address seals. The annual "mitten tea" proved remunerative and interesting. A major project of the current year is to be the furnishing of the Memorial Chapel which is being built in conjunction with the new nurses' residence. Graduates from near and far have contributed generously and it is hoped that the chapel will open in April or May.

The executive of the current year includes the following: Mrs. J. R. Milne, pres.; Mrs. R. Tregillis, 1st. vice-pres.; N. Baker, 2nd vice-pres.; Mrs. R. Parker, corr. sec.; Mrs. B. C. White, rec. sec.; Mrs. D. G. McInnes, treas. Mrs. J. D. Zmurchyk is the convener of the annual graduation banquet.

## BRITISH COLUMBIA

#### CRANBROOK

The annual chapter meeting took the form of a dinner party at the hotel. Twenty members attended this most successful event. The following slate of officers was elected: Mrs. C. Kram, pres.; Mrs. L. Truscott and N. Lee, vice-presidents; Mrs. C. Ferguson, sec.; M. Lewis, treas. An active year is planned with emphasis on graduate nurse education.

#### FERNIE

A regular meeting of the local chapter of the R.N.A.B.C. was held recently with election of the following slate of officers: Mrs. L. Hockley, pres.; Mrs. R. Miller, treas.; F. Gerwing, sec.

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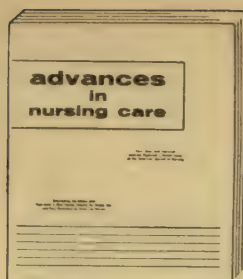
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### PENTICTON

Dr. W. A. Wickett was the guest speaker at a recent chapter meeting where attention was directed towards cardiac disorders and their treatment. Dr. Wickett's excellent address on heart disease was followed by a brief discussion of the nursing care in coronary thrombosis conducted by M. K. Darters.

The business session was conducted by Mrs. A. Mason and plans were completed for a dance under the convenership of M. Delaney.

The February meeting was held in the nurses' residence with an attendance of 31. The guest speaker, Miss J. Bennett, district supervisor of the social welfare branch of the provincial government, discussed many aspects of her work in the area and of social work in the province. A film entitled "A Friend at Your Door" provided glimpses of social work in action. The business session was conducted by the president, Mrs. A. Mason. M. E. Walker was appointed chairman of the scholarship committee while Mrs. H. Lenzie is on the hospital board.

### VANCOUVER

#### *St. Paul's Hospital*

Modern trends in medicine were discussed by Dr. J. W. Caldwell at the February meeting of the alumnae association. Nurses, who are no longer actively engaged in their profession, were given an excellent opportunity

to keep abreast of developments. Plans are progressing for the annual spring dance which will provide a climax to graduation week activities. The annual election of officers is to be held at the June meeting and members are being urged to keep this important event in mind.

The class of January '46 held their annual reunion at the home of T. (Goddard) Perry.

### VICTORIA

At the annual meeting of the chapter held at Veterans' Hospital recently, plans were made for a buffet supper to precede the Vancouver Island district meeting in February. Three institutes on Body Mechanics and Rehabilitation Nursing, arranged by the R.N.A.B.C. and conducted by Mrs. Grace Allan, were held in January and February. Seven hundred purse calendars with place and date of chapter meetings for 1956 have been mailed to registered nurses in this area.

Officers elected for 1956 were: President, Mrs. J. Jones; vice-presidents, Sister Mary Alena and Mrs. H. Woodhead; secretary, Miss G. Ballard; treasurer, Miss O. Wilson. Conveners of committees are: Programme, Mrs. Mattson; membership, Mrs. Damon; publicity, Miss A. Kelly; sick visiting, Miss J. Bompas. Serving in other capacities are N. Jones, E. Walther and B. Davis.

Business was followed by an excellent symposium on teaching obstetrics chaired by Miss E. Donaldson. Those participating were Dr.

C. Mellis Mair — The Obstetrician's Viewpoint; Miss B. Moore — The Obstetrical Nurse's Viewpoint; Miss B. Short — As the V.O.N. Teaches; Mrs. McMoyl — How the Patient Learns.

## MANITOBA

### BRANDON

Members of the Association of Graduate Nurses heard with interest of the changing picture of tuberculosis in this province. At a recent meeting, Dr. G. Coghlin, acting medical superintendent of Brandon Sanatorium stated that the yearly provincial death rate due to tuberculosis had dropped from 225 in 1950 to 64 in 1955. The introduction of the antituberculosis drugs had produced this reduction. On the other hand, there had been little or no decrease in the number of new cases since eradication of the disease calls for prevention which has not been generally achieved. Hospitalization is still a very important aspect of the treatment of this disease. Coloured slides emphasized the pertinent points of Dr. Coghlin's address.

The guest speaker for a subsequent meeting is to be Mrs. E. J. Skafel. The annual tea is to be held in the nurses' residence under the direction of Mrs. F. Moxham and I. Lamont.

### WINNIPEG

#### *General Hospital*

The alumnae association is planning to hold the annual Spring tea in the auditorium of the new nurses' residence late in May. The proceeds from this event will be used to purchase furnishings for the library — the main project of the association for this year. A tour of part of the building with 1956 graduates acting as guides is planned and it is hoped that an opportunity will be afforded for many to renew friendships and acquaintances.

#### *St. Boniface Hospital*

The annual meeting of the alumnae association was held in conjunction with a dinner party attended by 220 members. Ten members with a record fifty years of service as graduate nurses were awarded life memberships. They are M. Wannacott, A. Starr, Mrs. E. Montgomery, Mrs. G. A. Lyon, Mrs. E. A. Jones, Mrs. C. H. Chawn, Mrs. P. J. Cayle, Mrs. A. C. McLeod, Mrs. M. Parent and Mrs. A. Slater.

The new slate of officers was presented and installed. They are Rev. Sr. Clermont, honorary pres.; Mrs. R. H. McNaughton, pres.; T. Greville, first vice-pres.; Mrs. A. Lemoine, second vice-pres.; P. Hanna, recording sec.; B. Bolt, corr. sec.; Mrs. M. Shaw, treas.

## NEW BRUNSWICK

### MONCTON

Recent meetings of the chapter have been held in the nurses' residence. Mrs. L. Colwell reported from the nursing education com-

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mittee that H. McHale from the teaching staff of the Hôtel Dieu had attended the course at Civil Defence College, Arnprior. A. Crothers from the teaching staff of Moncton Hospital was a guest speaker at the high school. Her topic, "Nursing as a Profession," was presented to students interested in nursing as a career. J. Lewis is presently engaged in postgraduate work in psychiatric nursing.

A play was presented by members of the Nurses' Christian Fellowship and a successful dance was sponsored by the Students Council of Moncton Hospital. Mrs. D. Van Buskirk reported that teachers for the home nursing course were needed by the St. John Ambulance Association. It is hoped that further television programs related to St. John Ambulance activities can be arranged. Mrs. Van Buskirk also announced that Miss D. Walker, Chief Consultant of the National Health Division, Dept. of Health and Welfare, would hold an institute on public relations in May.

Dr. Austin Clarke, executive director of Moncton Hospital, was the guest speaker at the January meeting. His topic, "Health Insurance as It Affects Nursing," provided the members with much interesting information.

### SAINT JOHN

The annual meeting of the chapter was held in January with election of officers for the current year. Those serving include: W. Hooser, pres.; K. Donahue, 1st vice-pres.; H. D. McCallum, 2nd vice-pres.; A. Thorne, sec.; K. Christiansen, treas.

Committee reports indicated a successful year during 1955. Upon the recommendation of the provincial committee on publicity and public relations regarding the need for an educational program, a questionnaire is to be submitted to all members.

### General Hospital

Late in January, twenty-five student nurses received their caps at an impressive candle-lighting ceremony. Parents and friends of the students attended the event. Miss M. Archibald was the guest speaker for the evening. B. Taylor, E. M. Adair and L. Johnston received bursaries presented by the Altrusa Club, the Women's Hospital and the Alexander Chapter of the I.O.D.E. White testaments were presented by members of the Gideon Ladies Auxiliary.

Miss C. M. Gleeson, who recently retired as supervisor of the communicable diseases pavilion, was the guest of honor at parties given by the staff nurses and members of the alumnae association. On each occasion she was the recipient of a gift from those attending.

Early in February the annual meeting of the alumnae association was held. The slate of officers elected for 1956 is as follows: Mrs. J. Stirling, pres.; Mrs. E. T. K. Mooney, 1st vice-pres.; Mrs. G. Somerville, sec.; Mrs. D. Crawford, treas.

Of particular interest to members and friends of the alumnae association is the announcement that a "History of the Saint John General School of Nursing" is soon to be published.



## ONTARIO

### DISTRICT 3

#### GUELPH

##### *General Hospital*

Under the direction of Mrs. C. Gausden, the alumnae association recorded an active and successful year during 1955. Events included a tea and penny sale, the annual dinner in honor of the graduating class, an early summer picnic and a fall card party. The fall dance proved a financial and social success as usual. All activities were enthusiastically supported by the members.

The regular meetings offered much of educational value to those attending. Heart disease was discussed by Dr. W. C. Burchell at one meeting. Mr. D. Kennedy, president of the Rotary Club, was the guest speaker on another occasion, at which the film "None are Refused" was shown. The customs of Singapore were discussed by Mr. Yoe in November while at a previous gathering Dr. Norman High from the Ontario Agricultural College spoke concerning agricultural developments in England and Scotland. The annual bursary was presented to a student nurse. Various contributions of money were made to worthy causes during the year.

In January of this year, the election of officers took place. Members elected to serve for the current term include the following: M. Featherstone, pres.; Mrs. Donald Shaw, rec. sec.; Mrs. G. M. Elliott, corr. sec.; C. Ziegler, treas.

### DISTRICT 5

#### TORONTO

##### *General Hospital*

The past year saw many class reunions and plans were made for similar occasions this year. News of the members of the various classes showed varied activities. V. Lindabury accepted a position as clinical instructor at Royal Victoria Hospital, Barrie. E. Panter has returned to her home school as nursing arts instructor. A. Cheyne is now a nursing office supervisor following a period of postgraduate study. M. Murray recently retired from the social service department.

Attending the University of Toronto are: J. Enright and N. Lee, hospital administration; M. Parish, L. Martin and B. Bugar, public health nursing. A. Kimberley is presently taking postgraduate work at the Montreal Neurological Institute. P. Thompson has returned to the staff of the University Hospital, Edmonton following postgraduate study. O. Wolenska is engaged in polio nursing and M. MacArthur is in charge of the health service at the University Hospital, Edmonton. M. Bugar is on the staff of the V.O.N. in Peterborough while M. Helston is at the Peter Bent Brigham Hospital, Boston. D. Coggins has joined the staff of the East General Hospital. E. Matheson and J. Cameron are in Khartoum, Egypt. M. Alldred is now head nurse of the

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G. Wainwright, past pres.; Mrs. J. Olave-son, pres.; S. Brown, 1st vice-pres.; A. Rose, 2nd vice-pres.; D. Connell, rec. sec.; Mrs. O. Lunn, treas.; Mrs. C. Goodberry, corr. sec.

## DISTRICT 8

### OTTAWA

#### *Civic Hospital*

The annual meeting of the alumnae association was held in January. Officers for the current year were elected. It was reported that the rummage sale held late in the fall of 1955 was a financial success as well as a pleasant social event. An equally successful tea and sale was sponsored by the Memorial Organ Committee. The fund for the organ is still open for those who may yet wish to contribute. Late last fall a bridge party and sale of homecooking helped to swell alumnae coffers. This event was convened by Mrs. A. Thomson and Mrs. J. Argue.

Members will be interested to learn that the Agnes Hudson Chapter of the I.O.D.E. of Salmon Arm, B.C., has granted the first of its annual scholarships in memory of Gertrude M. Bennett. The award is given to young women of that district who wish to make nursing their career. The first recipient of a nursing bursary of \$450 awarded by an Ottawa newspaper to the Civic Hospital is K. Woodwork. Her mother, Ida (McDowell) Woodwork, is a graduate of 1930.

Developments within the hospital have included installation of a cobalt bomb for general use in the treatment of cancer. The trustees have recommended a four to five year expansion plan which would eventually increase the patient capacity by 300 beds. In addition other new departments and facilities would be accommodated.

News of the graduates includes the following items. F. Lyons is presently nursing in New York. J. I. MacLean has joined the staff of Toronto East General Hospital. M. Smith and B. Weightman are working in Coppercliff. M. E. Whitney is registered at the University of Toronto. D. (Lawrence) MacLachlan is working in Brooklyn, N.Y. B. Fanjoy, who recently returned from Africa, has joined the staff of Walter Reid Hospital, Washington. B. Barr has accepted a position as supervisor of obstetrics in the Toronto East General. E. McLennan has joined the staff as a clinical instructor while M. Logan-Vencta is in the teaching department. D. Montgomery is nurse in charge of the operating room in the new Doctor's Building. G. Foster is attending Ottawa University where she is majoring in nursing supervision. R. Lavshway and E. Gendron are attending University of Toronto and are enrolled in the teaching and supervision course. M. Graham is on the staff of the Leeds and Grenville Health Unit. E. Tingley is with the Lennox and Addington H.U. and D. Ogilvie has joined the Public Health Unit of Michipicoten Township. M. Robertson and E. Brash are presently working in Bermuda. W. Whaley, E. Michel, A.

women's section, Ward B with J. Smith, as her assistant. J. Inksater, R. Inkinen, I. Szekeres and M. Hood are also serving as assistant head nurses. E. Hill is head nurse of the women's division, Ward C and R. Kiratsu has replaced L. Humphrey as head nurse on Ward F. R. Leavens and J. Part-ridge recently resigned from the staff of the hospital. After many years of service in Vellore, India, L. Chute has returned to Canada.

At a recent meeting of the alumnae association, the following slate of officers was elected to serve for the current year: Mrs. M. Strong, pres.; J. Dodds, 1st vice-pres.; Mrs. K. Smith, 2nd vice-pres.; Mrs. W. A. White, sec.-treas.

#### *Women's College Hospital*

Members elected to the executive of the alumnae association for the current year include the following: Miss E. Fraser, pres.; Mrs. McMillen, rec. sec.; Mrs. L. Shapero, corr. sec.; Mrs. D. Gordon, treas.

## DISTRICT 6

### PETERBOROUGH

#### *Civic Hospital*

At a recent meeting of the alumnae association the following slate of officers was elected to serve for the current year: Mrs.



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SAINT JOHN, N.B.**

Lewis, G. Burpee and B. Pearson are on the staff of the Vancouver General Hospital, and E. Kidd, M. Kidd and D. Filson are working in the Peterborough Clinic. P. Legault is on the staff of the University Hospital, Edmonton as is P. Sharpe. S. Nixon is director of nursing at the Children's Hospital, Winnipeg.

## DISTRICT 12

### KAPUSKASING

The "Northern Chapter" recently formed in this area has recorded a most successful beginning in professional activity. The monthly meetings have been well attended, in spite of distances, and the programs have been of excellent calibre. The efforts of an energetic program committee promise plenty more gatherings of a similar nature. It is felt that this new organization will do much towards strengthening professional bonds and promoting good public relations among the nurses of this vast northern area.

## QUEBEC

### DISTRICT 11

### MONTREAL

*Queen Elizabeth Hospital*

The following slate of officers was elected

to direct alumnae activities for the current year: B. Cummings, pres.; Mrs. D. Renwick, vice-pres.; B. Mann, sec.; Miss Dornington, treas.; M. Bennett, assistant treas.; A. MacDonald, rep. to *The Canadian Nurse*.

### *General Hospital*

The traditional carol singing of the past Christmas took place in the setting of the new building. Those who remembered the open wards of the old hospital suffered pangs of loneliness as they watched the procession of carollers move through the long corridors. Mr. Bulford, who has contributed his services as organist for many years, was assisted by his son this season — the singers having been divided into two groups.

The alumnae association held their annual party in Livingston Hall — their first Christmas in new surroundings. Members were welcomed by Miss Odell. The main feature of the evening was a carol-sing led by members of the preliminary class.

I. Riley who received her B.Sc. degree from Teachers' College, Columbia University during this past year, is presently on the teaching staff of the Jewish General Hospital. A. Peverley received the degree of Master of Public Health from Yale University in May of last year. She returned to her position of assistant professor in public health nursing at the School for Graduate Nurses, McGill University. C. Denovan is now in charge of the dietitians' residence. F. Elford accepted an appointment as night supervisor.

The members elected to office for the current year of alumnae activities are: B. G. Herman, pres.; E. W. Odell, 1st vice-pres.; M. Allen, 2nd vice-pres.; M. Johnson, rec. sec.; J. Hackwell, corr. sec.; M. I. MacLeod, treas.

### DISTRICT 3

#### SHERBROOKE

A meeting of the English chapter was held late in January with Miss Suzanne Giroux, official visitor to French schools of nursing, as guest speaker. She gave a stimulating and vivid description of her recent visit to England, France and other European countries. A large number of students and several members of the French chapter attended the meeting.

### *Sherbrooke Hospital*

Members of the staff association were afforded the opportunity recently of hearing Dr. A. A. Dougan discuss electrolyte balance. At a subsequent meeting Dr. H. McDougall presented the latest developments in chest surgery.

The following slate of officers has been elected to direct alumnae activities for this year: Mrs. D. Lebrun, pres.; K. Vaughan, 1st vice-pres.; Mrs. G. Bryant, 2nd vice-pres.; Mrs. M. Mandigo, rec. sec.; Mrs. A. Morrison, corr. sec.; M. Beckwith, treas.; S. Carson, rep. to *The Canadian Nurse*.

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**Operating Room Supervisor, Night Supervisor & Staff Nurses.** Good salary & personnel policies. Living accommodations available. Apply Director of Nurses, General Hospital, Parry Sound, Ontario.

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**Psychiatric Nurse** to assume position as Head Nurse & Clinical Supervisor of new 38-bed Psychiatric Unit in a 500-bed General Hospital. An excellent opportunity for a Psychiatric Nurse who wishes to assume leadership in developing the policies, procedures & teaching program of this new Psychiatric Unit. Patients treated only by psychiatrists. The most modern facilities & treatment methods. Cooperative administration. Bachelor's Degree required plus Psychiatric experience. Salary commensurate with experience & abilities. Write Director of Nursing, Aultman Hospital, Canton, Ohio.

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**Asst. Director of Nursing** for active treatment modern 186-bed & a chronic unit 105-bed hospital with school of nursing for 60-75 students. Main responsibility, organization of nursing service. Excellent personnel policies include pension plan & paid hospital ins. Located in one of the most attractive cities in Ont. with pop. 20,000. Applications with full details to Director of Nursing, General Hospital, Stratford, Ont.

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**Charge Nurse & Supervisory positions** at Manitoba Sanatorium, Ninette, Man. Extensive chest surgery provides interesting work & worthwhile experience. Salary range: \$220-\$265 per mo. depending on qualifications & appointment. Board, room & laundry provided for \$45 per mo. Comfortable quarters in new nurses' residence. Generous vacation, all statutory holidays, group ins. & other employee benefits. Apply Sanatorium Board of Manitoba, 668 Bannatyne Ave., Winnipeg, Man.

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**Operating Room Supervisor & Assistant Head Nurses** for children's orthopedic hospital. Good personnel policies. Pension plan available. Apply Director, Shriner's Hospital for Crippled Children, 1529 Cedar Ave., Montreal.

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**Superintendent of Nurses** for 74-bed, 18-bassinette hospital with school of nursing. Located in the beautiful Annapolis Valley, 45 mi. from the city of Halifax, N.S. For full particulars apply W. L. MacQuarrie, Sec.-Treas., Payzant Memorial Hospital, Windsor, N.S.

**Director of Nurses** with training & experience in nursing administration & possessing a high supervisory ability for 115-bed hospital. Planning new hospital with regional facilities. Salary commensurate with capabilities. 40-hr. wk. Apply stating age, qualifications & experience to Administrator, General Hospital, Nanaimo, B.C.

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**General Supervisors, Operating Room Nurses and General Duty Nurses** for new 150-bed hospital. Starting salary for Registered General Duty Nurses \$230 with annual increases to \$40. 1½ days per mo. cumulative sick leave; 40-hr. wk; 28 days vacation; 10 statutory holidays. Apply: Supt. of Nurses, Trail-Tadanac Hospital, Trail, B.C.

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**Nursing Arts Instructor** for school of nursing. 200-bed hospital. 45 students. New teaching unit. Pension plan. Complete maintenance if desired. Good personnel policies. Apply Supt., General Hospital, Cornwall, Ont.

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**Operating Room Supervisor.** Starting Salary: \$300 per mo. **Graduate Nurses** for 100-bed West Coast General Hospital. Salary: \$250 per mo. less \$40 for board, residence, laundry. 3 annual increments; \$10 per mo. night duty bonus. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. cumulative to 36 days. Transportation allowance up to \$60 refunded after 1 yr. Apply Director of Nursing, General Hospital, Prince Rupert, B.C.

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**Supervisor (qualified.)** Good salary. Extra allowance for experience if French speaking. 5-day wk., 4-wk. vacation, 18 days sick leave cumulative annually. Car is provided. Half cost of uniform is allowed & half of Blue Cross. Workmen's Compensation. Good working conditions. Apply Sec.-Treas., Porcupine Health Unit, 164 Algonquin Blvd. E., Timmins, Ont.

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**Central Supply Room Supervisor** to organize & direct dept. in new 250-bed hospital. Experience in operating room &/or central supply desirable. Salary according to education & experience. Apply Supt., Children's Hospital, Winnipeg 4, Manitoba.

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**Operating Room Supervisor (1) & Nursing Arts Instructor (1)** for 110-bed hospital. Apply Supt., The Charlotte County Hospital, St. Stephen, N.B.

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**Assistant Evening Supervisor** for hospital with School of Nursing. Moving to new 250-bed hospital shortly. Apply Director of Nursing, Children's Hospital, Winnipeg 4, Man.

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**Educational Director for school of nursing.** 65 students. Good personnel policies including 44-hr. wk. Apply stating qualifications & experience to Miss B. A. Beattie, Director of Nursing, Public General Hospital, Chatham, Ontario.

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**McKellar General Hospital, Fort William, Ont. requires Clinical Instructor** in operating room. Gross salary commensurate with experience, 28 days vacation after 1 yr., 8 statutory holidays, sick leave accumulative to 60 days. Residence accommodation available at reasonable rates. Hospital has recently completed a well equipped & staffed wing with extensive renovation program progressing in the old section. Apply Director of Nursing.

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**Nursing Arts Instructor, Clinical Instructor (1)** to teach psychiatric nursing on male wards. **Clinical Instructor (1)** to teach psychiatric nursing on female wards. Salary: \$290 to \$345 per mo. **Graduate Nurses** preferably with psychiatric preparation. Salary: \$235 to \$275 per mo. 1450-bed active treatment hospital conducting an accredited school of nursing. 44-hr. wk. Residence with board, if desired, \$30 per mo. Excellent holiday, sick leave & pension benefits. Apply, stating qualifications & experience, Supt. of Nurses, Provincial Mental Hospital, Ponoka, Alta.

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**Obstetrical Clinical Instructor** for School of Nursing with capacity 195 students attached to expanding hospital of 571 beds. B.S. Degree in Nursing Education preferred or at least 3 yrs. experience & working towards degree. Located in "all American City" of 120,000 in North Eastern Ohio with educational, industrial, recreational & agricultural primary interests. Salary commensurate with qualifications. Write Director of Nursing, Aultman Hospital, Canton, Ohio.

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**Nursing Arts Instructor** for School of Nursing, with capacity 195 students, attached to expanding hospital of 571 beds. B.S. Degree in Nursing Education preferred or at least 3 yrs. experience & working toward degree. Located in "All American City" of 120,000 in North Eastern Ohio with educational, industrial, recreational & agricultural primary interests. Salary commensurate with qualifications. Write Director of Nursing, Aultman Hospital, Canton, Ohio.

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# REGISTERED NURSE

## Interested in Geriatrics

Capable of assuming responsibility & supervising staff of nursing assistants in an institution having 2 infirmary sections totalling 120-beds, well section having 140-beds.

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5141 NOTRE DAME ST. EAST, MONTREAL

**Night Supervisor & Operating Room Nurse** for 44-bed hospital. Liberal personnel policies. Living accommodation available in new residence. 44-hr. wk., 3-wk. vacation, 8 statutory holidays. For further information apply Supt., Haldimand War Memorial Hospital, Dunnville, Ont.

**Instructor in Nursing.** Faculty position in medical area. Accredited integrated diploma program. Northern California college community. Liberal personnel policies. Excellent clinical & teaching facilities. Progressive faculty. 90 students. Immediate opening. For details write Personnel Office, 510 E. Market St., Stockton, California.

**Instructor** for school of nursing — Applications are invited for 138-bed hospital. This school is affiliated with Montreal hospitals, the teaching schools associated with McGill University. For particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

**Registered Graduate Nurses for General Duty** for 650-bed Tuberculosis Hospital, 10 mi. from downtown Toronto. Gross starting salary: \$93 bi-weekly, less \$15.23 for room, meals & laundry. 3 annual increments. 44-hr. wk., 8 hr. day, broken hrs. 3 wk. vacation after 1 yr., 9 statutory holidays. Hospital bus service to & from city. Apply Supt. of Nurses, Toronto Hospital, Weston, Ont.

**Registered Staff Nurses,** immediate appointments, in 511-bed newly enlarged and finely equipped general hospital. Duty assignments in medical, surgical, pediatrics, psychiatric, obstetrics, or contagion units. Northeastern Ohio stable "All-American City" of 120,000. In centre of area of recreational, industrial, and educational friendly activities. Living costs reasonable. Within pleasant driving-distance advantages of metropolitan Cleveland and Columbus, Ohio and Pittsburg, Pa. Friendly, cooperative work relations and conditions. Progressively advanced personnel policies. Starting salary: \$240 per mo. with 4 merit increases. Paid vacation, sick leave, recognized holidays, premium pay, sickness insurance and hospitalization program, retirement. Contact: Director of Personnel, Aultman Hospital, Canton, Ohio, by letter or collect telephone 4-5673.

**Registered Nurses for General Duty.** Initial salary: \$200 per mo.; with 6 or more months Psychiatric experience, \$210 per mo. Salary increase at end of 1 yr. 44-hr. wk.; 8 statutory holidays, annual vacation with pay. Living accommodation if desired. For further information apply Supt. of Nurses, Homewood Sanitarium, Guelph, Ont.

**Registered Nurses for General Duty Staff.** Salary commences at £40-10-0 per mo. with full maintenance. Transportation allowance. For full particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

**Registered Nurses (3)** immediately for 36-bed General Hospital in southern Manitoba. Starting salary: \$210 per mo. with 3 wk. vacation with pay 1st. yr. employment; 4-wk. vacation thereafter. All statutory holidays. Regular sick leave, 50%. Blue Cross payments. Apply Supt. of Nurses, Hospital Dist. No. 24, Box 330, Altona, Manitoba.

**Registered & Non-Registered Nurses, X-Ray & Lab. Technician** for General Hospital. Gross salary for nurses registered in Ont. equivalent to \$233.85 per mo. Good personnel policies, new facilities. 8-hr. rotating shifts; 44-hr. wk.; 1-day off 1 wk. & 2 the next. 1½ days holiday & sick leave per mo.; 8 legal holidays per year. Up to \$40 travelling expenses & increase paid after 1 yr. service. Semi-private Blue Cross with M.O.S. coverage. Full maintenance is provided including room, board & laundering of uniforms. Apply Supt., Lady Minto Hospital, Cochrane, Ont.



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School of Nursing has two other full time instructors — Student enrollment 40. Salary commensurate with experience. 31-day vacation after 1 year. Statutory holidays. 40-hr. wk. Good personnel policies & consideration for sickness & hospitalization. Accommodation available in attractive new residence. Population of Sherbrooke 60,000, 100 miles from Montreal, easily accessible by daily bus & train service. Good recreational facilities.

Apply to:

**DIRECTOR OF NURSING, SHERBROOKE HOSPITAL, SHERBROOKE, QUEBEC**

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**Registered General Duty Nurses** for 18-bed hospital. Salary: \$240 less \$30 perquisites with yearly increase of \$10 per mo. 44-hr. wk. Vacation with pay, all statutory holidays, liberal sick leave. For further information please telephone collect to Miss H. Moore, Matron, Union Hospital, Oxbow, Sask.

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**Registered Nurses.** Salary: \$225 per mo. gross. 5-day wk. Single room residence. 20 miles east of Toronto. Apply Supt., Ajax & Pickering General Hosp., Ajax, Ont.

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**Registered Nurses** for Psychiatry. Student affiliation or postgraduate work preferred. For information apply Director of Nursing, Victoria Hospital, London, Ont.

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**Registered Nurses (1 or 2)** for 24-bed hospital. Salary: \$190 per mo. Full maintenance. Usual increases after 6 mo. Holidays, sick leave. Modern nurses' home. Apply Matron, Union Hospital, Vanguard, Saskatchewan.

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**Registered Nurses & Certified Nursing Assistants** for general duty. 44-hr. wk., annual vacation with pay, statutory holidays. For further information apply Supt., of Nurses, General Hospital, Cobourg, Ont.

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**Assistant Head Nurses, Surgical, Obstetrical & General Duty Nurses** for 355-bed General Hospital. Starting salary: \$260, \$270 for afternoons & nights. Apply Director of Nursing Service, St. Vincent's Hospital, 2447 N.W. Westover, Portland 10, Oregon.

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**Registered Nurses for Supervision & General Duty** in 150-bed Tuberculosis Hospital. 31-day annual vacation, 7 statutory holidays, 44-hr. wk. Three \$5.00 increments every 6 mo. Residence facilities available. Apply stating age, experience & salary expected to Director of Nursing, Grace Dart Hospital, 6085 Sherbrooke St. E., Montreal, Que.

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**Registered General Duty Nurses** for new 58-bed hospital situated in North Western Ontario. Opening about Sept. 1, 1956. Salary: \$215 per mo. subject to increase after 6-mo. with regular annual increase thereafter. \$45 per mo. room & board. 30 days vacation & rail fare refunded after 1 yr. service. New 21-bed nurses' residence, each room having an adjoining bathroom. Apply stating age & when available to Frederick Taylor, Administrator, Dist. General Hospital, Dryden, Ont.

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**Registered Nurses** for 18-bed General Hospital. Salary: \$225 less \$30 for full maintenance. 44-hr. wk., 10 statutory holidays. Beautiful part of B.C. Apply Matron, Arrow Lakes Hospital, Nakus, B.C.

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**Registered Nurses (2, experienced)** for 50-bed hospital. Salary: \$185 per mo. plus full maintenance with \$5.00 increases every 6 mo. for 2 yrs. For further information apply Matron Municipal Hospital, Wainwright, Alberta.

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**Registered Nurses** for 28-bed hospital, 48 mi. southeast of Montreal. Salary \$150 per mo. \$5.00 increment every 6 mo. to maximum \$165 plus full maintenance. 1 mo. annual vacation with pay, all statutory holidays, 2 wk. sick leave, Blue Cross paid. 8-hr. day, rotating shifts. Wonderful summer resort 8 mi. from Lake St. Francis. T.V. in nurses' residence. Apply Mrs. M. G. Curran, County Hospital, Huntingdon, Que.

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**General Staff Nurses** for 400-bed Medical & Surgical Sanatorium, fully approved student affiliation & postgraduate program. Full maintenance. Recreational facilities. Vacation with pay. Sick benefits after 1 yr. Blue Cross coverage. Attractive salary; 40-hr. wk. For further particulars apply Supt. of Nurses, Nova Scotia Sanatorium, Kentville, N.S.

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**Where?** Jeffery Hale's Hospital

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**DIRECTOR OF NURSES, JEFFERY HALE'S HOSPITAL, 1250 ST. FOY, QUEBEC, P.Q.**

**General Staff Nurses** for fully accredited, private teaching hospital located on Lake Michigan, just north of Chicago. Salary range: \$303-\$328.70. Shift bonus, \$26 afternoons & \$17 nights. 5-day, 40-hr. wk. Progressive personnel policies. Excellent cafeteria & attractive rooms at reasonable rates. Please indicate type of service preferred. Apply Director of Nursing, Evanston Hospital, 2650 Ridge Ave., Evanston, Illinois.

**Staff Nurses (all services)** for 325-bed General Hospital 20 min. from downtown Detroit. Starting salary: \$315, after 1 yr. \$336. 40-hr. wk., rotating shifts. 2-wk. vacation, 16 days sick leave, 6 legal holidays per yr. without loss of salary. Medical, surgical & life insurance benefits. Must be eligible for Michigan registration. Apply Director of Nursing, General Hospital, Highland Park 3, Michigan.

**Staff Nurses for 600-bed General & Tuberculosis Hospitals with School of Nursing.** Salary: \$288-\$341. Shift, special service & educational differentials, \$10. 40-hr. wk; 3-wk. vacation; 11 holidays; accumulative sick leave. Apply Associate Director of Nursing Service, County General Hospital, Fresno, California.

**Staff Nurses** for 100-bed hospital. Gross salary commences at \$2,100. Apply Supt. of Nurses, Western Memorial Hospital, Corner Brook, Newfoundland.

**Staff Nurses & Operating Room Scrub Nurses** for 225-bed General Hospital on outskirts of New York City. Salary \$240-\$280; \$20 extra for O.R. duty; \$30 for permanent evening duty; \$25 for permanent night duty. Apply Director of Nursing, St. John's Riverside Hospital, Yonkers, N.Y.

**Operating Room Nurses,** immediate appointments, for 511-bed newly enlarged and finely equipped hospital; 10 operating rooms now completed. Northeastern Ohio stable "All-American City" of 120,000. In centre of area of recreational, industrial and educational friendly activities; living cost reasonable. Within pleasant driving-distance advantages of metropolitan Cleveland and Columbus, Ohio, and Pittsburg, Pa. Friendly and considerate working associates and conditions. Progressively advanced personnel policies. Starting salary: \$240 per mo. with 4 merit increases. Paid vacation, sick leave, recognized holidays, premium pay, sickness insurance and hospitalization program, retirement. Contact Director of Personnel, Aultman Hospital, Canton, Ohio, by letter or collect telephone 4-5673.

**Operating Room Nurse & Registered General Duty Nurses** for very active General Hospital. Good salary & personnel policies. 44-hr. wk., 8 statutory holidays. Residence available. Apply Director of Nurses, Peel Memorial Hospital, Brampton, Ont.

**Operating Room Scrub Nurses** with experience for new operating suite near completion, finely equipped. Salary open depending upon preparation or experience. Desirable working conditions. Travel expenses if necessary. Apply Supt. of Nurses, Union Hospital, Moose Jaw, Saskatchewan.

**Operating Room Nurses (2)** for 60-bed General Hospital. Apply Superintendent, Leamington District Memorial Hospital, Leamington, Ontario.

**General Duty Nurses** for 430-bed hospital; 40-hr. wk. Statutory holidays. Salary: \$235-268. Credit for past experience. Annual increments; cumulative sick leave; 28 days annual vacation; B.C. registration required. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.



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Position vacant August 1956. Modern classrooms & facilities. Present student enrolment 54. New 85-bed nurses' residence to be opened in fall. Salary commensurate to qualifications. Liberal personnel policies.

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**General Duty Nurses** for 650-bed teaching hospital in central California. Salary: \$288-\$337 per mo. 40-hr. wk. Liberal vacation, holiday & sick leave plan. Apply Personnel Office, 510 E. Market St., Stockton, California.

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**General Duty Nurses.** Salary: \$230-270, \$10 increment for experience. 40-hr. wk. 1½ days sick leave per mo. cumulative; 10 statutory holidays, (1) mo. vacation. Must be eligible for B.C. registration. Apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

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**General Duty & Surgical Nurses** for 64-bed acute treatment, fully accredited hospital in Northern California. Excellent living conditions. Close proximity to vacation areas for leisure time. Full details at once on salaries, working conditions, paid holidays, paid vacations, paid sick leave & other benefits. Please apply Director of Nursing Services, Clinic Hospital, Woodland, California.

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**General Duty Nurses** for 30-bed General Hospital. Excellent working conditions, personnel policies & recreational facilities. Apply Miss M. I. Baker, Supervisor of Nurses, Joyce Memorial Hospital, Shawinigan Falls, Que.

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**General Duty Nurses for Medical, Surgical, Pediatrics, Obstetrics.** Good salary & personnel policies. Apply Director of Nursing, Victoria Hospital, London, Ont.

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**Royal Jubilee Hospital, Victoria, B.C.** invites applications for **General Duty Nurses** for permanent positions & vacation relief in 500-bed General Hospital. Salary \$227.50-\$262.50. 5-day, 40-hr. wk. 4-wk. vacation. 10 statutory holidays. Pension plan. Attractive employee benefits. Apply, Director of Nursing.

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**General Duty Nurses** for all departments. Gross salary: \$210 per mo. if registered in Ontario \$200 per mo. until registration has been established. \$20 per mo. bonus for evening or night duty; annual increment of \$10 per mo. for 3 yrs. 44-hr. wk., 8 statutory holidays, 21 days vacation & 14 days leave for illness with pay after 1 yr. of employment. Apply: Director of Nursing. General Hospital, Oshawa, Ont.

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**General Duty Nurses** for 110-bed General Hospital situated in the beautiful Fraser Valley, 68 mi. from Vancouver. Good bus service. Salary: \$230 per mo. Personnel policies in accordance with R.N.A.B.C. agreement. 40-hr. wk. Residence accommodation. Apply Director of Nursing, General Hospital, Chilliwack, B.C.

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**General Duty Nurses (4)** for modern active 45-bed hospital. Busy town of 2,500. Daily bus to N. Battleford & Saskatoon. Basic salary: \$225 per mo. les \$30 per mo. for maintenance. 8-hr. rotating shift. Separate nurses' residence. Transportation by bus or rail up to an amount of \$50 allowed after 1 yr. service. Apply stating age & experience to Matron, Union Hospital, Meadow Lake, Sask.

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**General Duty Nurses** for 65-bed hospital. Gross salary: \$185-\$210. 44-hr. wk., statutory holidays. For further information apply Director of Nursing Services, General & Marine Hospital, Collingwood, Ont.

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**General Duty Nurses.** All shifts, no rotation. Starting salary \$290, increases to \$349 plus shift differential of \$10. Specialty services, **Ob-Peds-Tb-Isol** \$10-\$15 extra. 5 day wk. 3-wk. vacation end of 1st yr. 11 statutory holidays each yr. Nurses' home available at \$15 per mo. Ideal location, short distance from San Francisco or mountain resort areas. Apply Director of Nurses, Stanislaus County Hosp., 830 Scenic Drive, Modesto, California.



## GRENFELL LABRADOR MEDICAL MISSION

The Grenfell Mission operates four Hospitals & seven Nursing Stations in northern Newfoundland & on the Labrador. Here is a wonderful opportunity for valuable experience & an adventurous life. If you are making plans for next year, why not consider this splendid service still carried on in the name of a great man?

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MISS DOROTHY A. PLANT, SECRETARY, GRENFELL LABRADOR MEDICAL MISSION  
48 SPARKS ST., OTTAWA 4, ONTARIO

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**General Duty Nurse (O.R. experience)** for 70-bed hospital on B.C. coast. Salary: \$222-\$242 per mo. less \$25 full maintenance. 28-day vacation plus 10 statutory holidays after 1 yr. Apply Matron, Saint George's Hospital, Alert Bay, B.C.

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**General Duty Nurses** for well equipped 47-bed hospital. 8-hr. duty, 5½ day wk. Annual vacation with pay, statutory holidays. Full maintenance in new modern residence. For further information apply Supt., General Hospital, Kincardine, Ont.

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**General Duty Nurse for Surgical Unit** handling thoracic & orthopedic surgery. For further information please apply Director of Nursing, Fort William Sanatorium, Fort William, Ont.

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**General Duty Nurses.** Good personnel policies. Apply The Superintendent, Espanola General Hospital, Espanola, Ont.

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**Graduate Nurses** for 8-bed hospital. Salary: \$275 per mo. plus full maintenance which includes board, room & uniforms laundered. 5-day wk., 8-hr. shifts. Apply Dr. Jack C. Nichols, Dept. of Public Health, Mono County Hospital, Bridgeport, California.

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**Graduate Nurses for general staff duty** in tuberculosis hospital for the treatment of adult medical patients. For further information apply The Director of Nursing, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Que.

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**Baker Memorial Sanatorium, Calgary, Alberta,** offers to Graduate Nurses a 6-mo. post-graduate course in Tuberculosis. Maintenance & salary as for general staff nurses. Opportunity for permanent employment if desired. Spring & Fall Classes. Further information on request.

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**Graduate Nurses (3)** for 24-bed hospital. Salary: \$230 per mo. if B.C. registered; less \$40 board, lodging, laundry. 1 mo. vacation after 1 yr. on full pay. 1½ days sick leave per mo. cumulative. Apply, stating experience to Matron, Terrace & District Hospital, Terrace, British Columbia.

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**Graduate Nurses (2)** for 64-bed hospital 250 mi. northwest Edmonton. Good train & mail service. Salary as recommended by R.N.A. of Alberta, increments of \$5.00 every 6 mo. for 2 yrs. \$30 room & board. Transportation allowance up to \$50 after 1 yr. service. 28 days paid vacation after 1 yr. plus 10 statutory holidays. 1½ days sick leave per mo. Apply Sr. Superior, Providence Hospital, High Prairie, Alta.

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**Graduate Nurses (General Staff Positions)** for General Hospital. Salary: \$235.50 per mo. as minimum & \$273.75 as maximum, plus shift differential for evening & night duty. 40-hr. wk. Temporary residence accommodation is available. Applicants not registered in B.C. should forward a letter of acceptance of registration in B.C. from the Registrar of Nurses, 2524 Cypress St., Vancouver, B.C. Please apply Personnel Dept., Vancouver General Hospital, Vancouver, B.C.

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**Graduate Nurses (Labor & Delivery Rooms)** for 100-bed unit in maternity hospital. Apply Director of Nursing, Royal Alexandra Hospital, Edmonton, Alberta.

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**Graduate Nurses** for 29-bed General Hospital — 2 positions open. Beginning salary: \$250 per mo. 2-wk. vacation with pay. Sick benefits, Blue Cross Hospitalization & Social Security Benefits. Apply Business Manager, Otis Hosp., Inc., 441 E. Market St., Celina, Ohio.

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Qualified Dietitians for 445-bed hospital. Large student school. Salary commensurate with qualifications & experience. New & modern Dietary Dept. Cafeteria and tray-vendor service. Day shifts only. Liberal holidays, sick leave, pension plan & other perquisites. Excellent quarters & working conditions. Transportation refundable after 6 months.

Apply

DIRECTOR OF DIETETICS, McKELLAR GENERAL HOSPITAL, FORT WILLIAM, ONTARIO

**Graduate Registered Nurses** for general duty for 118-bed General Hospital along the shores of Lake Michigan, 25 mi. from Chicago. Base salary \$300. Good personal policies. Apply Highland Park Hosp., Foundation, 718 Glenview Ave., Highland Park, Ill.

**Graduate Nurses & Dietician (1)** for new, very modern 88-bed hospital in a pleasant progressive town. Nurses salary: \$200 per mo. Annual increase \$10 per mo. for 3 yrs. 2-wk. shift rotation, bonus for night shifts. 1 hr. drive to Toronto & several resorts. Local swimming pool, bowling alleys, skating, theatres etc. Apply Director of Nurses, Dufferin Area Hospital, Orangeville, Ont.

**General Duty Nurses (one, May 1 — one, June 1)** for 15-bed hospital. Starting salary: \$175 plus full maintenance with \$5.00 increases each 6 mo. for 2 years. 1 mo. vacation with pay per yr. Usual holidays. Nurses' quarters in hospital. Daily C.N.R. & bus services. Write, phone or wire The Matron, or Sec., F. J. M. Lijdsman, Municipal Hospital, Oyen, Alberta. Telephone No. 6 or 23-51.

**Laboratory Technician** for 65-bed hospital, experienced in urinalysis, haematology, chemistry & blood bank. Living accommodation available. For further information apply Administrator, General & Marine Hospital, Collingwood, Ont.

**Laboratory Technician (experienced).** Good salary. Living accommodation available. Please advise immediately if interested to Administrator, General & Marine Hospital, Collingwood, Ontario.

**Supervisor of Public Health Nursing** for generalized program in city of 43,000. 5-day wk., 1 mo. vacation with extra time at Christmas or Easter. Cumulative sick leave. Pension plan, Blue Cross & P.S.I., Workmen's Compensation. Transportation provided or allowance. For further information please write supplying details of training & experience to Dr. J. P. Wells, M.O.H., Peterborough, Ont.

**Public Health Nurses** for generalized program in Seaway Development Area. Minimum salary: \$2,700 with allowance for experience. Group insurance & Blue Cross available. Good transportation policy. Apply R. S. Peat, M.D., Medical Officer of Health, S. D. & G. Health Unit, 104 Second St. W., Cornwall, Ont.

**Public Health Nurse Grade 1.** British Columbia Civil Service, Dept. of Health & Welfare. Starting Salary \$255, \$260, \$266 per mo., depending on experience, rising to \$298. per mo. Promotional opportunities available. Qualifications: Candidate must be eligible for registration in British Columbia & have completed a University degree or Certificate course in Public Health Nursing. (Successful candidates may be required to serve in any part of the Province.) Cars are provided. 5-day wk. in most districts. Uniform allowance. Candidates must be British subjects; preference is given to ex-service women. Application forms obtainable from all Government Agencies, the Civil Service Commission, 544 Michigan St., Victoria, or 411 Dunsmuir St., Vancouver 3, to be completed & returned to the Chairman, Civil Service Commission, Victoria. Further information may be obtained from the Director, Public Health Nursing, Dept. of Health & Welfare, Parliament Bldgs., Victoria, B.C.

**Public Health Nurses (qualified).** Generalized program in urban area. Starting salary: \$2,900-\$3,200 depending on experience. Annual increment \$150. Transportation provided. 5-day wk. Pension Plan. Hospitalization & sickness insurance available. Apply A. F. Mackay, Board of Health, City of Oshawa, Ont.



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**INITIAL SALARY: \$225 PER MONTH, PLUS LAUNDRY**

**EXCELLENT PERSONNEL POLICIES**

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**DIRECTOR OF NURSING, SUDBURY MEMORIAL HOSPITAL,  
REGENT STREET SOUTH, SUDBURY, ONTARIO**

**Public Health Nurses.** Duties to commence between June & Sept. 1956. Salary: \$2,796-\$3,396. 5-day wk., 1 mo. vacation, pension plan. Apply Dr. W. H. Hill, M.O.H., Dept. of Health, Calgary, Alta.

**Public Health Nurses for Kent County Board of Health.** Minimum salary: \$2,840 with annual increases of \$150 per yr. for 4 successive yrs. 38-hr. wk., 3-wk. vacation with pay, all statutory holidays, 2-days per mo. sick leave accumulative to 48 days. Uniforms provided. Ideally located, bordered on the south by Lake Erie & by Lake St. Clair on the west. The City of Chatham being located in the centre of the County with the cities of London, Sarnia & Windsor, Ont. & the City of Detroit, Mich. all within 1-hr. drive from Chatham, makes Kent County a most desirable place in which to live & make a living. Apply W. M. Abraham, Sec.-Treas., Kent County Board of Health, 7th St., Chatham, Ontario.

**Public Health Nurse for elementary school service.** Please state qualifications, experience, salary expected. Duties to commence as soon as possible. For further information write A. W. Blowes, County Clerk, County of Perth, Court House, Stratford, Ontario.

**Public Health Nurse for Town of Deep River.** Salary: \$3,005 to \$3,395 depending on qualifications. Pension, medical & vacation plans. Living accommodation in staff hotel. State all particulars including age, marital status, education & experience in first letter to "File 2A", Atomic Energy of Can. Ltd., Chalk River, Ontario.

**Public Health Nurse** for the Peace River Health Unit. Duties to commence April 1/56. Salary in accordance with Provincial schedule. Apply Sec. Health Unit, Peace River, Alta.

**Public Health Nurses (qualified.)** Salary: \$3,100 depending on dist. served, less if in the Timmins area. Annual increment \$150 per annum for 4 yrs. Additional allowance for experience & if French-speaking. 5-day wk. 4-wk. vacation, 18 days sick leave annually (cumulative.) Car is provided. Half cost of uniform is allowed & half of Blue Cross. Workmen's Compensation. Good working conditions. Apply Sec.-Treas., Porcupine Health Unit, 164 Algonquin Blvd. E., Timmins, Ont.

**Public Health Nurse (qualified)** for generalized program. Salary according to previous experience with annual increases. 3-wk. annual vacation. Pension Plan. Car allowance or car provided. Apply Director Public Health Nursing, Box 404, Charlottetown, P.E.I.

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Newest hospital in Toronto, situated on The Queen Elizabeth Way, 12 miles from downtown Toronto. Attractive residence facilities available in the new apartment type residence now under construction. Hospital scheduled to open August 1, 1956.

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# THE CANADIAN NURSE

## *L'Infirmière Canadienne*

VOLUME 52

NUMBER 5

MAY 1956

- 325** PRE-REGISTRATION FORM  
**328** NEW PRODUCTS  
**337** SERVICE, RESPONSIBILITY, NURTURE,  
ACTION ..... *M. T. MacKenzie*  
**339** HISTORIC MANITOBA  
**341** STARTING FROM SCRATCH.....*M. Kathleen Ruane*  
**345** UN ENFANT EST NÉ TROP TÔT.....*R. Saint-Martin*  
**347** NURSES: THEIR EDUCATION AND  
THEIR ROLE IN HEALTH PROGRAMS  
**350** CONVENTION PERSONALITY  
**351** A CHILD WITH LARYNGOTRACHEO  
BRONCHITIS ..... *Sr. M. A. Cecilia*  
**357** SOME CONSIDERATIONS ON THE  
BASIC NURSING CURRICULUM ..... *G. B. Carter*  
**361** USING CASE HISTORIES TO LEARN ..... *C. E. Morehouse*  
**363** IN MEMORIAM  
**366** NURSING ACROSS THE NATION  
**370** LE NURSING À TRAVERS LE PAYS  
**376** TICKET OF NOMINATIONS  
**380** DISH-WASHING CENTER ..... *G. Barker*  
**382** SÉLECTION  
**384** BOOK REVIEWS  
**389** NEWS NOTES  
**398** EMPLOYMENT OPPORTUNITIES

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# Between Ourselves

**J**UST 12 YEARS AFTER Saskatchewan entered confederation as an organized province a small group of forward-looking leaders of nursing sought and obtained official recognition for a brand new body, the Saskatchewan Registered Nurses Association. Incorporated in 1917, the S. R. N. A. has developed into a strong professional organization in which each of the present 2,900 members is given a feeling of being part of something vital and full of purpose. On their behalf, our guest editor, **Mary Tinnock MacKenzie**, extends hearty greetings to the nurses of Canada.

A native daughter of the province where she serves as president of the nurses' association, Miss MacKenzie early decided she was going to be a teacher. After a short teaching experience in the public schools, she entered St. Boniface School of Nursing. It was very natural that she should become a nursing arts instructor at St. Boniface following her graduation. When she had secured her certificate in teaching and supervision from the School of Nursing, University of Manitoba, she joined the teaching staff at St. Paul's Hospital, Saskatoon. For the past six years she has been clinical coordinator there. Off duty activities include a joy in gardening and reading.

\* \* \*

This is the second year in which the Macmillan Company of Canada Limited has presented prizes to student nurses for the best descriptions of comprehensive nursing care. Eight faculty members in schools of nursing from V. G. H. in Halifax to V. G. H. in Vancouver gave thoughtful consideration to the entries. They awarded the first prize of \$25. to **Sister Mary Ann Cecelia**, a second year student at St. Joseph's Hospital, Victoria. Her study of a child with laryngotracheo bronchitis is included here. The second prize of the same value was won by Miss Rita Ziehran, a senior student at University Hospital, Edmonton, Alta. Her article and three of those winning honorable mention will be published in successive issues. Students from Misericordia Hospital, Winnipeg — Lily Watanabe and Mary Dersco — won the two top places in honorable mention. Sister Mary Doris from St. Joseph's, Victoria, won third place. The article of Sister Mary Edmund of Hotel Dieu Hospital, Cornwall, Ont. that

won fourth place was published in our November, 1955 issue.

Who will win first place and \$25 for the article submitted during 1956? Send along your studies of comprehensive nursing care, student nurses!

\* \* \*

With the 28th biennial convention only a matter of a few weeks away, pleasurable anticipation is mounting. An interesting account of the adventure-packed **history of Manitoba** appears in this issue. Next month there will be a story of the city of Winnipeg with particular reference to the University of Manitoba. This background information will serve to orient the lucky ones who are able to go to the convention.

If you have postponed pre-registering because of uncertainty regarding attendance, please complete the form that appears on the opposite page and send it in immediately to National Office. Remember to send a money order for your registration fee — \$5.00 for graduate, \$2.00 for students. **Pre-registration** is essential before you can apply to the Housing Committee for living accommodation at the convention. When you arrive at convention headquarters next month and go to the Registration Desk to pick up your reports and papers, you will be asked to produce both your pre-registration receipt and your current provincial registration card. The latter serves as a valuable identification piece on any occasion. It is particularly important to identify you at the convention.

We have been requested to give a **special reminder to student nurses — take your uniform** with you to Winnipeg. As noted in the Tentative Program last month, there is a special session for students only, on Tuesday morning, June 26. Every student is to wear her full school uniform for that occasion. It should add greatly to the interest of the session and will certainly rate pictorial recording so have your cameras loaded, girls.

Two years ago the practice of printing all committee reports in a pre-convention issue was discontinued. The folio of reports will be available to all those attending. Following the convention, the National Office staff will prepare an official record of business transacted, reports given, addresses and

(Please turn to page 331)

# PRE-REGISTER FOR THE 28th BIENNIAL MEETING

## THE CANADIAN NURSES' ASSOCIATION UNIVERSITY OF MANITOBA, WINNIPEG JUNE 25 - 29, 1956

Name .....  
Address .....  
Province in which registered ..... Number.....  
Active Member ..... Associate member .....  
Classification (please insert check mark where applicable) : Institutional .....  
Private nursing ..... Public health ..... Industrial ..... Other .....  
(specify)  
Staff ..... Supervision ..... Teaching ..... Administration .....

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When you have completed this form, please :

1. Send it to

**CANADIAN NURSES' ASSOCIATION  
270 LAURIER AVENUE WEST  
OTTAWA, CANADA**

2. Enclose registration fee of five dollars (\$5.00) — fifteen cents exchange if submitted by cheque.

You will then receive :

1. A receipt for registration fee.
2. Card to be presented at Registration Desk at Convention.
3. Identification certificate for convention rail rate if required.
4. Application card for accommodation.

### STUDENT NURSES

Name .....  
Name of School of Nursing .....  
Address .....

Please return form with registration fee \$2.00 — .15 cents exchange rate on cheques.

A badge and program will be issued to each one at Registration Desk at the Convention giving admittance to all sessions for the period of the Convention.

Note: Graduate nurses must present proof of registration or associate membership with a Provincial Nurses' Association at the Registration Desk.

# INSCRIPTION ANTÉRIEURE AU 28<sup>e</sup> CONGRÈS BIENNAL

## L'ASSOCIATION DES INFIRMIÈRES CANADIENNES UNIVERSITÉ DU MANITOBA, WINNIPEG 25 - 29 JUIN, 1956

Nom .....  
Adresse .....  
Enregistrée dans la province ..... Numéro .....  
Membre active ..... Membre associée .....  
Classification (Veuillez inscrire une marque à la place appropriée) :  
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Administration ..... Autre .....  
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Veuillez s'il vous plaît retourner la partie supérieure de cette forme avec le montant d'inscription \$5.00 — et quinze sous pour prix d'échange par chèque :

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**L'ASSOCIATION DES INFIRMIÈRES CANADIENNES  
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1. Reçu pour votre argent.
2. Carte qui doit être présentée au bureau d'enregistrement au Congrès.
3. Certificat d'identité du Congrès pour tarifs du chemin de fer, si requis.
4. Forme d'application pour logement.

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# New Products

Edited by DEAN F. N. HUGHES

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**Administration**—One-half to one teaspoonful 1 to 3 times daily. Contraindicated in convulsive conditions, epilepsy, chorea.

---

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**Description**—Each yellow scored tablet represents: Butisol sodium (sodium 5-ethyl-5 sec. butyl barbiturate) 15 mg., reserpine 0.1 mg.

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**Administration**—One to 4 tablets daily as required in doses of 1 tablet 3 or 4 times daily or 2 tablets twice daily.

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**Description**—Each troche contains 50 units of bacitracin, 1000 units of polymyxin B and 5 mg. benzocaine.

**Indications**—Infections of the mouth and throat.

---

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**Administration**—Usually 1 or 2 pulvules 3 times daily. Each pulvule (125 mg.) is equivalent to approximately 200,000 units of penicillin.

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*The Journal presents pharmaceuticals for information. Nurses understand that only a physician may prescribe.*

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This course provides study in nursing and in the sciences and humanities. It prepares for practice under the Nurses Registration Act of the Province of Ontario. Graduates are qualified for all branches of community and hospital nursing. Provision is made for practice in the hospitals in Toronto in the summer months. An alternate arrangement permits completion of the course over a five year period with practice through an internship year following the 2nd year. Students are eligible for employment as Registered Nurses on completion of the internship. This plan makes it possible for students to assist themselves financially.

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Length: 3 years

This course provides studies in the humanities, basic sciences, and nursing. Applicants select a field of professional specialization such as Hospital Nursing Service, Nursing Education or Public Health Nursing.

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1956-1957

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For additional information, write to:

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#### FIORINAL

**Manufacturer**—Sandoz Pharmaceuticals, Division of Sandoz (Canada) Ltd., Montreal.

**Description**—Each tablet contains: Sandoptal NNR 50 mg., caffeine 40 mg., acetylsalicylic acid 200 mg., phenacetin 130 mg.

**Indications**—Tension headaches.

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**Description**—Tablets: Vitamin C 50 mg., hesperidine methyl chalcone 25 mg., rutin 25 mg., esculin 2 mg., vitamin K (menadione sodium bisulphite) 5 mg. Also available in injectable form.

**Indications**—Capillary hemorrhages — prevention and treatment.

**Administration**—Orally, 4 to 8 tablets daily; parenterally, one vial daily in the desired dilution, by hypodermic, intramuscular or intravenous injection.

#### JUVALIN

**Manufacturer**—British Drug Houses (Canada) Ltd., Toronto, Ont.

**Description**—Each two capsules provides: Ethinyloestradiol 0.02 mg., methyltestosterone 6 mg., thyroid 8 mg., ascorbic acid 50 mg., quercetin 10 mg., thiamine mononitrate 2 mg., riboflavin 2 mg., niacinamide 20 mg., pyridoxine HCl 1 mg., vitamin B<sub>12</sub> amorphous 3 mcgm., choline bitartrate 250 mg.

**Indications**—For use in preventive geriatric medicine.

**Administration**—Average dose is 2 capsules daily.

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**Manufacturer**—Schering Corporation Limited, Montreal, P.Q.

**Description**—Each tablet contains 0.75 mg. of prednisone (meticcorten), 325 mg. of acetylsalicylic acid, 20 mg. of ascorbic acid, and 75 mg. of aluminum hydroxide.

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**Teaching of Sciences, Maternal & Child Health** (Students may choose either Pediatric or Obstetric Nursing as a major field of interest).

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*For further information write to:*

**Director, McGill School for Graduate Nurses,  
1266 Pine Ave. W., Montreal 25, Que.**

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**Administration**—Apply 3 or 4 times daily to the affected area.

*(Continued from page 324)*

panels presented. Post-convention-wise, the *Journal* will carry a day-by-day account of convention activity in the August issue; the Presidential address, and the Keynote address will appear in September. As is customary, the Mary Agnes Snively Memorial Lecture is scheduled for October, together with Dr. Adelaide Sinclair's address. In the

November number we will present the paper given by Miss Margaret Arnstein during the Nursing Service program and the one given by Miss Mildred Schwier at the Nursing Education session.

We cannot all go to Winnipeg, of course. The next best thing to being there yourself is to read about it all in your own copy of *The Canadian Nurse*.

# UNIVERSITY OF BRITISH COLUMBIA

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N.B.: The School of Nursing also offers, for high school graduates with University Entrance, a Basic Professional Course leading to the degree of B.S.N.

For further information write to the

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Director of Nurses,  
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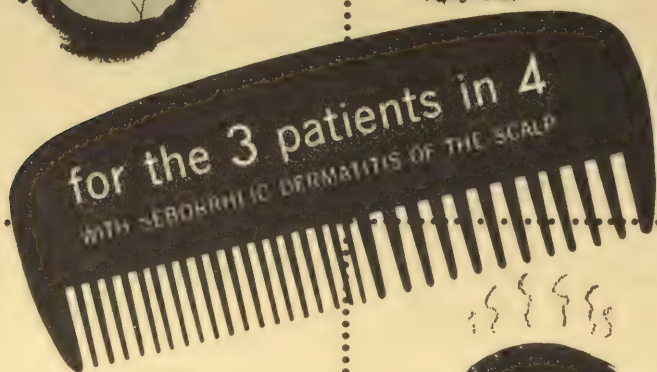


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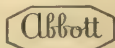




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# THE CANADIAN NURSE

## *L'Infirmière Canadienne*

A MONTHLY JOURNAL FOR THE NURSES OF CANADA  
PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION

VOLUME 52

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MONTREAL, MAY, 1956

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# Service, Responsibility, Nurture, Action

ON THIS, THE FIRST OCCASION when two provinces are sharing the honor of acting as hostesses at a CNA biennial meeting, it is my privilege and pleasure to send a message to the nurses of Canada.

To the nurses of Saskatchewan, the name "Saskatchewan Registered Nurses' Association" has special meaning and implication. Each word suggests a special message.

"Saskatchewan"\* — an Indian word meaning "swift current," implies service. The name of our province comes from this river, whose source is high in the Rockies. Beginning as a very

small stream, it gathers to it the waters from its feeding streams until it becomes a mighty river — a source of valuable service to mankind.

Our provincial association also began in a small way. From a very meager beginning as a recognized professional association in 1917, with a membership of 317 registered nurses, we have grown to an active membership in 1955 of 2921. This body of nurses, working in widely varied fields of activity, participate vigorously in the health services to the people of our province.

"Registered" — this provides legal recognition of status. With registration comes added responsibility. Dur-

\*The Cree word — Kisiskatchewan



MARY T. MACKENZIE

ing the 1953-1957 quadrennial period, between ICN congresses, this has been emphasized, since "responsibility" has been selected as our watchword.

"Nurses" — The word "nurse" means "to nurture." The nurse must evidence at all times her readiness to serve all members of the community, regardless of race, color or creed. Her ever-present concern must be for the health and welfare of *all* those whom she is privileged to serve.

"Association" — This is defined as a group of people organized for a

specific purpose. A nursing association is organized in the interest of nursing and health services generally. This implies action, progress. One can but look at the growth and development of our association in the past 39 years to realize that "activity" and "action" are key words in the life of our members, and thus of our Association.

We realize that "service," "responsibility," "nurture" and "action" are all a part of the lifeblood of nurses and nursing across Canada. The heart of Canadian nursing will be centred in Winnipeg as we gather at the CNA biennial meeting, June 25 to 29. Here our efforts will be renewed to strengthen our associations both nationally and provincially.

Program activities that have been planned forecast important possibilities for future action. We will not forget that our primary function is "to nurture" and we will be prepared to accept our responsibility, both as nurses and citizens of Canada, for our part in the health and welfare program of the community as we plan how nursing can better serve the nation.

MARY T. MACKENZIE  
*President*  
Saskatchewan Registered  
Nurses' Association

## Are You Hoping to go to Rome?

The Canadian Nurses' Association is pleased to announce the appointment of Thos. Cook & Son as the travel agents who will make arrangements for members planning to attend the Congress of the International Council of Nurses in Rome in 1957. Mrs. Grace Arliss of Thos. Cook & Son will be available in Winnipeg during the forthcoming CNA convention for any preliminary discussions.

Because of the limitation of space in the Congress auditorium, each member country has been assigned a quota — for Canada, approximately 250. This number has been apportioned out among the provincial nurses'

associations on the basis of their total membership. It has been necessary to set an arbitrary time limit on the filing of applications under this quota system. *The list closes in September, 1956.*

Nurses who are interested in attending the Congress should apply quickly to the Canadian Nurses' Association, 270 Laurier Ave. West, Ottawa, Ontario. Speedy filing of applications will facilitate beginning to plan for travel arrangements with Thos. Cook & Son. Those nurses who are unable to consult Mrs. Arliss in Winnipeg will find the addresses of Thos. Cook & Son agencies listed on page 391.

First a man learns to talk. After many years he learns to keep still.

Reputation can be purchased for a price, but there is no price tag on character.



# Historic Manitoba

FROM THE RICH GRAINLANDS and pleasant valleys of the south and west to the northern wilderness of forests and lakes, Manitoba offers the visitor striking contrasts in scenery and holiday recreations. It also provides much of interest for the historic-minded tourist, for many relics and monuments of its colorful past remain.

Manitoba's history was made by explorers and missionaries, fur-traders and settlers; men fascinated by the mystery of the undiscovered land, or intent on establishing homes in the new country; and others, spurred on by a vision of riches, or dedicated to the founding of a Christian community in the wilderness.

The first of the early explorers to reach the waters of far northern Manitoba was the English sea captain, Henry Hudson. Turned adrift by his mutinous crew, he died off the rocky coastline of the great bay that bears his name.

To a Welshman, Sir Thomas Button, goes the credit of having been the first white man to set foot on what is now Manitoba soil. In 1612, he

sailed along the western shore of Hudson's Bay and wintered at the mouth of the Nelson River. It was Button who took possession of the country in the name of the King of England, thus giving Manitoba the distinction of having been under one flag longer, second only to Newfoundland, than any other place on the North American continent.

In 1670 King Charles II granted a charter to "The Governor and Company of Adventurers Trading into Hudson's Bay" and the cornerstone of a vast trading empire was laid. The Hudson's Bay Company established forts in the far north, to which the Indians brought their furs. Of this early period in the province's history, the ruins of Fort Prince of Wales may still be seen at Eskimo Point, Churchill, on Hudson's Bay. This ancient fort was captured by a French sea force in 1782 and partially demolished. Sections of the 42-foot-thick walls still remain, while spiked and dismantled guns lie rusting on the ramparts.

The first white man known to have seen the prairies was Henry Kelsey,



*Provincial Legislative Building, Winnipeg*

(C.P.R. Photo)

a Hudson's Bay Company trader and explorer. Between 1690 and 1692, this adventuresome wanderer, who kept an account of his journeys in rhyming verse, pushed inland from the Bay to eastern Saskatchewan, travelling via what is now The Pas in northern Manitoba. In that town may be seen a cairn commemorating his achievements.

Almost half a century later, other white men reached the west by travelling inland over the long water route from Montreal. In 1738 a group under Pierre Gaultier de la Verendrye built a fort at the junction of the Red and Assiniboine Rivers. Fort Rouge was thus the first building on the site of the future city of Winnipeg.

Several cairns in the province honor La Verendrye and his sons, for the group pressed far westward, some say to the foothills of the Rocky Mountains, as well as into North Dakota. They also established a number of forts in Manitoba. Cairns may be seen at Morden in southern Manitoba; at Portage la Prairie, where Fort La Reine was built in 1739; at Windygate Road, on Highway No. 3; and at Winnipegosis, site of Fort Dauphin. Meanwhile, in a small park in St. Boniface, a magnificent life-size group in bronze commemorates the intrepid and tireless explorer.

Later, other fur-traders from Montreal followed La Verendrye's route into the western interior. It took them beyond the Lake of the Woods, up the wild waters of the Winnipeg River, cutting through the northern section of what is now the Whiteshell Forest Reserve, and into long, shallow Lake Winnipeg. From here they crossed to the Saskatchewan River and on to such posts as Cumberland House on the Saskatchewan, Ile à la Crosse on the Churchill and distant Fort Chipewyan on Lake Athabaska. These men were traders and voyageurs of the North West Company, rivals to the Hudson's Bay men. No trace remains of the forts they erected in Manitoba but the approximate sites of three are now marked. The first and second Fort Gibraltors, near the forks of the Red and Assiniboine, are noted on a plaque inside the old Fort Garry gate in Winnipeg; and at Morden a cairn overlooking a pretty lake stands near

the site of Fort Financewaywining.

The first attempt to found a permanent settlement in Manitoba and to farm the rich prairie soil came in 1812. In that year the Scottish earl, Lord Selkirk, sent out his first group of colonists. Crofters and fisherfolk from the Highlands, they settled on the banks of the Red River, where Fort Douglas was built as headquarters of the colony. In spite of many disasters, including crop failures and floods, and in the face of the North West Company's hostility, the tiny settlement prospered and formed the nucleus of the present city.

A cairn in William Whyte Park opposite the C.P.R. station, not far from where Fort Douglas stood, honors Winnipeg's Scottish founders. Late in 1955, a monument to Lord Selkirk was unveiled on Memorial Boulevard, while in a small park on Main Street the Seven Oaks monument marks the spot where Governor Robert Semple and 20 settlers were massacred by a group of Metis, at the instigation of the Nor' Westers.

As a reminder of the old fur-trading days, Manitoba is fortunate in possessing what is probably the only stone fort, still intact and in good condition, to be found anywhere on the continent. This is Lower Fort Garry, 19 miles north of Winnipeg on Highway No. 1. The fort, built in 1831, was used for a short time as official headquarters of the Hudson's Bay Company. In Winnipeg, meanwhile, the gateway to Upper Fort Garry still stands, all that remains of the establishment from which the Company ruled the west.

The regime of the Company ended in 1869 and the year following, Manitoba became a Canadian province. Between the two events occurred the Red River uprising, when the Metis resisted the territory's transfer without the consent of its inhabitants. Under Louis Riel, a provisional government was set up. Then on July 15, 1870, Manitoba formally became part of the Dominion and in August a military force under Sir Garnet Wolsey reached Red River from the east.

Riel, who was later hanged for his part in the North West Rebellion, is buried beside St. Boniface Basilica, where a shaft marks the last resting place of the man remembered vari-



ously as a traitor and a patriot.

Winnipeg was incorporated as a city in 1873. Five years later, a railway went through from St. Boniface to the U. S. border. With the completion of the C.P.R. line in 1885, a tide of immigration flowed into the province and development was rapid.

Today, the visitor to Manitoba may

pass from pretty, long-established farming centres, such as Deloraine and Wawanesa, where local museums or cairns recall the day of fur trade or early settlement, to the vast stretches of the relatively undiscovered north-land. Here, in a country whose wealth in minerals and timber is as yet almost untapped, history is still in the making.

## Starting from Scratch

KATHLEEN RUANE

### The New University Hospital Organizes the Nursing Service Department

ON THE MORNING OF JANUARY 25, 1956, the patient census at the University Hospital at Saskatoon was 380, a year ago the census was zero. On January 26, 1955, the first patients crossed the threshold of this magnificent greystone building to experience the standard of medical and nursing care that modern techniques and equipment can provide. Many hundreds have followed those first few patients in the intervening months. All manner of personnel are going about their work with an air of purpose and familiarity with their surroundings. Problems known in other days and in other hospitals nudge one's elbow and it is hard to realize that the hospital is a mere fledgling from the standpoint of time.

Although careful planning and organizing had been taking place for some months before "admission day," the sensations experienced by the nursing staff were, I imagine, similar to those of a cast in an important play before opening night. A few days before the patients were to be admitted a group of nurses was in the Nursing Office discussing last minute preparations when one member, recalling her classes in Civil Defence, suggested a "test run" for 24 hours with nurses

playing the role of patients. By this means, it was agreed, we would discover whether or not the bright new pieces of equipment were functioning properly and if the policies and techniques were sound and practicable. When other departments such as admitting, pharmacy, dietary, laboratory, etc., were asked if they would like to participate in the rehearsal, their response was most enthusiastic. The medical staff cooperated by leaving fantastically long lists of orders. Obviously our bogus patients were very



M. KATHLEEN RUANE

Miss Ruane is director of nursing of University Hospital, Saskatoon, Sask.



ill and only complicated tests could establish a diagnosis and many treatments effect a cure! It was necessary to send one patient to the operating room. As anticipated the "test run" did reveal some minor weaknesses in routines and that a few pieces of equipment were missing. But also it was heartening to find that, basically, the plan for nursing service had been sound.

What were some of the other steps in the planning? Walking through the long empty corridors in August, 1954, it was difficult to visualize them peopled with bustling nurses or to imagine the unfinished wards providing a comfortable environment for hundreds of patients with varying degrees of illness. But, at the desk and in committees, using the yardsticks recommended by the experts in the field of nursing, we were able to calculate the number and kinds of personnel required in all the nursing departments. Yet, we could not take these recommendations *in toto* and apply them to our situation. Attention had to be given to the scope and function of other departments, to the general standard of care to be established, to the nursing resources of the community, and to the concept of nursing organization within the nursing population.

Another factor influencing our deliberations on staffing requirements was that all student nurses appearing on the wards would be novices in the practice of nursing and there would be no senior students! The University Hospital was unique in the annals of hospital construction in that its completion ushered into being a new school of nursing and in formulating the program for student nurse education, the combined Boards of Directors of the University of Saskatchewan and the University Hospital established the policy whereby nursing education would be separated from nursing service. The University School of Nursing would plan and administer the curriculum and direct the rotation of the students through the clinical services.

Early in September, 1954, four key nurses were appointed, namely, the operating room supervisor, central supply service supervisor, nursing arts instructor and the supervisor of

the surgical service. In November, an assistant director of nursing service and a head nurse for the medical and surgical stations, respectively, were added to the staff. As a further course of action, three committees were formed.

1. *Committee on Nursing Procedures*: The purpose of this committee was to draw up and compile in a Procedure Book a list of procedures acceptable both to the school of nursing and the nursing service. The chairman was the nursing arts instructor who met with her committee every week. Outlines of procedures to be discussed would be circulated to the members a week in advance so that they would come prepared to make revisions if necessary. At all times the group was mindful of the principles of work simplification and the need for standardization wherever feasible. After the procedures were approved by the nursing committee, they were processed through a medical committee for comment. Our Procedure Book has been under constant revision since the hospital opened. That is not disappointing for we had met with the understanding that, though the procedure appeared to be the most sound, simple and practical ever devised, only application in our situation would prove it possessed all these qualities.

2. *Committee on Equipment for the Nursing Department*: The purpose of this committee was what the name implies. The chairman was the central supply service supervisor who prepared detailed lists of supplies and equipment which were scrutinized closely for possible omissions. In spite of checking and rechecking some of us harbored a secret fear lest a simple but vital piece of equipment, such as a glass connector, would be forgotten.

3. *Committee on Nursing Service Organization*: This was an all-embracing one and was concerned not only with the function of nursing service in general but also with how the service would coordinate its activities with all the other departments. The committee, therefore, had three objectives:

- (a) Devise a handbook on hospital policies and routines, assemble all records and requisitions affecting the nursing department.

(b) Plan a pattern of nursing staff organization for all nursing departments, this to include number and type of personnel together with job descriptions.

(c) Formulate personnel policies for the nursing staff; plan and implement an in-service education program.

The chairman of this committee was the director of nursing and three sub-committees were set up to deal with the objectives outlined above. The conveners of the sub-committees were selected from the existing staff on the basis of their preparation and expressed interest. Again, meetings were held each week; if the data on the agenda affected other departments, representatives were invited to attend so that we might arrive at a mutually acceptable working arrangement.

Herman Finer has written regarding nursing administration:

We are faced in hospitals with a number of diverse departments — x-ray, pharmacy, laundry, maintenance, laboratory, dietary, admission and purchasing — all of which must be brought together by the nurse. In the necessity for co-ordination, to secure the best possible focus of service, the right proportion, the right timing of all these various services, the nurse plays the part of

focus and funnel and channel, an applier to the particular imperative — that particular patient.

During those early months we were to learn that Finer "knew well of what he spoke."

I will dwell no longer on the intricacies of planning but, before moving on to other fields, I would like to pause here to pay a word of tribute and acknowledgment to those pioneering stalwarts without whose enthusiastic initiative the emergence of a well organized nursing service would not have been possible.

Needless to say the University Hospital boasts the most modern features in hospital construction and so, naturally, the adoption of modern methods and a recognition of newer trends was the keynote of our endeavors. In an age when a universal shortage of registered nurses existed, traditional patterns of nursing in terms of groupings and numbers would not appear to meet our staffing needs. Auxiliary personnel consisting of nursing assistants, ward aides and orderlies, would of necessity comprise a substantial proportion of the nursing staff. The team concept of nursing organization was instituted with student nurses,



The team leader, second from the right, discusses nursing care plans with her team members who are, left to right, a ward aide, nursing assistant and a student nurse.



nursing assistants and aides as members of the team. In certain areas where student nurses would not be available, a reallocation of duties revealed that a ratio of 1:1 professional to non-professional personnel would provide safe and good patient care.

At the time of writing, plans are being made for the introduction of nursing assistants into the operating rooms, there to be trained as surgical technicians. The selection of the nursing assistant for this role in preference to a person without previous hospital experience is based on the premise that the former already has had some instruction in the fundamentals of asepsis and bacteriology, and would be more readily oriented to the department. As on the wards, the technician will work under the direction of a registered nurse in the performance of duties which do not require professional skill and preparation.

Some cherished dreams of an earlier day were realized. Now the housekeeping department cooperates in performing *all* the housekeeping duties and no longer does a member of the nursing staff "carbolyze" and make up the bed and clean the room after a patient is discharged. The dietary department serves the meal trays to the patients and returns the used trays to the kitchen.

We have a communications system which is effective yet economical of time and which eliminates the practice of written reports from the supervisors to the nursing office. Now the assistant director "makes rounds" of all the nursing stations and departments about 3:00 p.m. and reports the state of the hospital — that is, the number of critically ill patients, emergencies,

special nurses called and for whom, staffing needs and adjustments, administrative problems and changes in routine affecting staff — on the tape recorder in the nursing office. The evening supervisor listens to this report when she comes on duty and later gives her 12 midnight report on the recorder. The night supervisor, on taking over her tour of duty, "runs off" the tape recorder and is made familiar with the day as well as the evening report. This system has many advantages:

1. It takes less time than written reports.

2. It is more accurate than repeated verbal reports.

3. There is no overlapping or delay at the end of a tour of duty. One supervisor does not have to wait until the end of a shift to give a verbal report to the relieving supervisor. The relieving supervisor does not have to wait for her counterpart to finish last minute details before hearing the report.

4. Each day supervisor comes to the Nursing Office when it is convenient for her and listens to the report on the tape recorder for the previous 24 hours.

A very brief written report from each station containing patient census, admissions, discharges, a description of critically ill patients or unusual occurrences, is received in the nursing office at the end of each shift for statistical purposes. A carbon copy is retained on the station. At the present time we are not convinced that a tape recorder, which costs approximately \$435, is an economical installation to have on each nursing station but, no doubt, a satisfactory routine could be developed. At present the kardex is referred to when giving the verbal report from one tour of duty to another.

In order to secure nursing staff for the new hospital, it was necessary to recruit registered nurses not only from various parts of Canada but from other countries of the Commonwealth. One of the challenging problems of the nursing department was to bring these nurses, plus auxiliary personnel, together and direct their energies toward a common objective — that of good and safe care of the patient — with a maximum of efficiency and a minimum of confusion.



The evening supervisor gives her 12:00 m.n. report onto the tape recorder.



As was mentioned earlier a sub-committee had been formed to plan an orientation program. The convener of the committee was the assistant director of nursing service and her subsequent responsibility has been the implementation of the program with representatives from the various departments participating where necessary. New staff members are enrolled according to categories in groups of six to ten on specified dates of the month. They are made familiar with the general policies of the institution, the conditions of employment, the routines of the departments to which they are assigned. They are introduced to the people with whom they will work, to the prevailing nursing pro-

cedures and instructed on the "team plan" of patient assignment.

The University Hospital Ward Manual and the Nursing Procedure Book are the texts for the orientation program and there is an adjustment in emphasis, content and length of time in the presentation of the material to the different categories of personnel.

Over 400 beds are now available to patients but there still remains an area of approximately 100 beds to be activated. The University Hospital has come through its first year of existence without major complications and bids fair to enjoy a busy, interesting and very long life. Those of us who helped to guide the first steps of infancy look with great expectations to its maturity.

## Un Enfant est Né Trop Tôt

ROBERT SAINT-MARTIN, M.D.

**L**A VIE, pour la plupart d'entre nous, a commencé neuf mois avant la date figurant dans notre certificat de naissance. Ce délai de neuf mois est nécessaire pour permettre à l'organisme de se développer et de vivre hors du sein maternel. Mais les êtres qui naissent avant ce délai sont-ils pour autant condamnés à mourir ou à rester irrémédiablement des êtres faibles et déficients? Qu'on se rassure: à notre époque de progrès techniques, l'enfant né prématurément a beaucoup plus de chances qu'autrefois de se développer normalement et de devenir, lui aussi, un être vigoureux et sain.

Ces enfants, en effet, par suite de leur extrême immaturité et de leur très grande fragilité, nécessitent un isolement absolu dans des locaux autonomes, un personnel spécialisé, formant une équipe homogène et disciplinée, enfin des techniques, méthodiquement réglées, de réchauffement, d'oxygénation et de diététique, pratiquées avec une asepsie rigoureuse.

Pour donner une idée générale de ces techniques, nous allons suivre,

étape par étape, le séjour d'un prématuré dans le service des prématurés à l'Hôpital Sainte-Justine.

Marie-José est née le 12 octobre, prématurée de 28 semaines, d'une mère de 20 ans. A sa naissance, elle pesait une livre et quinze onces. L'enfant a crié immédiatement et n'a pas eu besoin d'être ranimée. Elle est restée vingt minutes à la maison où elle est née, puis transportée, par ambulance spéciale dans un incubateur portatif pourvu d'un dispositif réchauffant et d'une bouteille d'oxygène, au centre des prématurés de l'Hôpital Sainte-Justine.

A son arrivée, Marie-José a été aussitôt replacée dans un incubateur (isolette) sous une concentration d'oxygène de 40 à 60% et reçut une injection de vitamine K. Dans ce dernier appareil, la température est maintenue au degré voulu; l'air filtré arrive mélangé d'oxygène, à la concentration désirée; un certain taux d'humidité est maintenu entre 60 et 90%, enfin le vitrage de l'appareil permet une surveillance constante.

Nous avons cherché à stabiliser la température de l'enfant aux environs de 96° durant tout le premier mois. Elle n'a reçu aucune alimentation pen-

Docteur Saint-Martin est chargé du Service des Prématurés, Hôpital Sainte-Justine, Montréal, Qué.

dant les quatre premiers jours: la respiration précaire, les oedèmes, le poids, avaient dicté cette ligne de conduite. Puis l'alimentation fut assurée à la sonde oesophagienne (eau sucrée, puis lait écrémé acidifié).

Au point de vue thérapeutique en dehors de la vitaminothérapie (K le premier jour, A B C et D par la suite) l'enfant a reçu 5 à 6 gouttes de cognac par jour pendant les deux premières semaines, comme stimulant respiratoire. Enfin une solution de lactate Ringer à partir du troisième jour, et une transfusion au dixième jour.

Le poids de l'enfant de une livre et quinze onces le premier jour, était de une livre et onze onces le 10e jour; de une livre et quinze onces (reprise du poids de naissance) le 21e jour; de deux livres et deux onces le 25e jour; de trois livres le 50e jour.

L'état de l'enfant a été très précaire pendant les dix premiers jours de sa vie du fait de l'atélectasie pulmonaire manifeste: respiration superficielle, thorax creusé en entonnoir à la fin de chaque expiration, apparition de cyanose dès que l'oxygène était diminué. Cependant aucun trouble grave (infection, vomissements, diarrhée) n'est venu interrompre la croissance. Peu à peu, tout est rentré dans l'ordre; l'aspect foetal avait disparu après deux semaines. L'enfant va remarquablement bien, est vigoureuse, et boit seule

maintenant. Nous avons cessé l'oxygénothérapie et les yeux sont normaux.

Les naissances prématurées ne sont pas rares: on en compte environ un sur douze naissances à terme. Vu qu'à Montréal, une naissance prématurée sur quatre se produit à la maison ou dans une maternité, l'Hôpital Sainte-Justine a créé un centre spécialisé pour l'élevage des plus petits prématurés, c'est-à-dire, de ceux pesant moins de cinq livres, la plupart moins de quatre livres.

S'il est vrai que, pour organiser un tel centre, il faut procéder à certains aménagements indispensables, disposer d'un équipement minimum, il faut surtout pouvoir compter sur une équipe de personnel qualifié et spécialisé.

"Une bonne infirmière," notait Clément Smith, "fait preuve d'une dextérité presque merveilleuse en soignant ses jeunes patients. Elle sait quels enfants exigent relativement peu de soins et quels sont ceux qu'il faut veiller et stimuler presque continuellement. Souvent, elle se rend compte, avant le médecin, qu'un enfant ne va pas bien; elle fait preuve alors de beaucoup de doigté pour que le médecin puisse s'en rendre compte par lui-même. Ses qualités sont un mélange d'amour pour son travail, d'expérience et d'observation. Sa formation prend du temps, mais en vaut la peine."

## Institute on Communications

A two-day institute on "Communications" was held for the graduate staff nurses at St. Mary's Hospital, Montreal, on February 9 and 10, 1956. The subject related to the almost unending chain of interpersonal relationships in nursing.

The director of the institute was Miss Mildred Walker, nursing consultant, Occupational Health Division, Department of National Health and Welfare. Because of her marked interest in the subject and her long experience in the field of human relations, Miss Walker was well-equipped to stimulate thinking. The Sisters, members of the faculty, and graduate nurses, all participated in group discussions. These were conducted in the light of "communications" around problems which had been depicted previously at a staff meeting when Dr. Margaret Nix was the guest speaker. Reports

were given by each recorder at the general meeting.

In her conferences, Miss Walker presented barriers and gateways to communication. These revolve around one's ability or inability to listen intelligently, understandingly, and skilfully to another person. To become objective and understand the other's point of view, hastens mutual communication and dropping of barriers. The final conference was based on the principles of good communication as prepared by the American Management Association.

The 80 nurses who attended were enthusiastic in their comments. All felt they had gained considerable insight which should prove of tremendous value in maintaining and improving their future relationships.

SISTER M. FELICITAS



# Nurses: Their Education and Their Role in Health Programs

*Note:* What are the services of professional nurses in Canada today? What does the profession see in the years ahead? What changes are necessary in the future if nurses are to make an even greater contribution to the nation's health?

These questions are of vital concern to all Canadians. Many indications of the answers are to be found in the following summary statement of the Canadian Nurses' Association, prepared for

the International Council of Nurses to be submitted at the Ninth World Health Assembly in 1956. This statement was assembled from facts and views presented by the CNA's 10 provincial nursing associations, representing some 40,000 registered nurses across Canada. It takes a look at today and a glimpse at tomorrow. Above all, it reflects the thoughtful forward-looking concern of the organized profession with the future of nursing in Canada.

\* \* \*

## WHAT IS THE PRESENT ROLE OF NURSES?

**B**ROADLY SPEAKING, the nurse aids in the conservation, restoration and promotion of the physical and mental health of the individual and the community.

*Whom does she serve?* The nurse gives service to:

Patients and their families in hospitals, clinics and homes.

School children and their parents within the school health programs.

Workers and their families within occupational health services.

Parents and their children in maternal and child health programs.

Communities in rural and urban public health services.

*What does she do?* She gives nursing care in all types of mental and physical illness, at home and in hospitals.

She assists with the rehabilitation of handicapped persons.

She assists with the maintenance of a healthful environment and the control of communicable diseases.

She teaches the principles and practice of the conservation and promotion of mental and physical health.

She administers and supervises all nursing service and participates in planning for health services.

She organizes, administers and participates in the education of professional and auxiliary nursing personnel.

She organizes, administers and participates in activities of professional nursing organizations. These activities include the promotion of legislation for the control of the practice of nursing; the establishment of requirements for registration and of standards of nursing education; and the advancement of the economic welfare of nurses.

## WHAT DO NURSES SEE AS THEIR FUTURE ROLE?

*Constantly evolving:* The role of the nurse will continue to evolve with social changes, advances in medical practice, and developing health programs.

*Leadership to increase:* She will assume leadership in the development of nursing in all health services and particularly in the coordination of these services. She will give leadership and direction in the education and service of all nursing personnel.

*Spirit and service unchanged:* It is expected that the nurse will continue to give the same forms of nursing service as at present but with greater emphasis on her function in health teaching and rehabilitation.

*Mental health:* She will participate more effectively and to a greater extent in mental health programs and in the care of the mentally ill.

*Maternal and child health:* Her role will be broadened in developing maternal and child health programs and



particularly in the area of the normal growth and development of the child.

*More research:* She will increase her participation in research to determine the nursing needs of society and the most effective ways of meeting these needs.

*Human dignity:* In order to fulfil the role envisaged in the future for the nurse she will continue to bear in mind the value and dignity of the human individual.

#### WHAT CHANGES IN CONDITIONS, ATTITUDES OR EDUCATIONAL FACILITIES ARE NEEDED IF NURSES ARE TO CONTRIBUTE SUCCESSFULLY TO THE FUTURE OF CANADIAN HEALTH?

##### THE NEEDS OF NURSING SERVICE

*Social research:* The nursing profession must be aware of the social forces that influence the type and extent of health care and nursing service needed by Canadians. It must be able to plan cooperatively with other health workers and the public in meeting the changing health needs of our society.

*Nursing research:* The functions of nursing must be evaluated. The levels of nursing personnel needed to carry out these functions must be established. The functions and responsibilities of each type of worker should be clearly stated.

*Auxiliary personnel:* Professional nurses must understand and appreciate the work of auxiliary nursing personnel. They must be prepared to delegate duties and provide leadership and supervision in order that a high quality of nursing service may be maintained as efficiently and economically as possible.

*Public understanding:* Allied professions and the public must be made aware of the services that each worker is prepared to give. This will enable governing boards and administrators of hospitals and other health agencies to create a situation where each worker can give the type of service for which she is best prepared.

*Nurse consultants for government:* There should be more nurse consultants in government to interpret the role of nursing in health services and

to participate in planning health programs.

*Administrative skills:* Improved practices and procedures based on sound management principles should be established in the administration of all nursing services. These should include:

Provision of adequate numbers of prepared staff to give the quality and quantity of nursing services necessary to meet all the needs of the patient. This service should include the spiritual and emotional aspects of nursing and provide for health teaching and rehabilitation.

Orientation and in-service education programs to increase the interest and efficiency of nursing personnel.

Establishment of sound personnel policies. This includes pension plans and group health insurance to provide the economic security and job satisfaction necessary to attract and retain well qualified personnel.

Provision of adequate physical facilities and equipment to ensure the greatest efficiency and economy of nursing service.

*Proper licensing:* Legislation, preferably on a national basis, should be introduced to provide for the licensure of all who nurse for hire. The professional nurses' organizations should determine the requirements for licensure and control the practice and discipline of their own members.

*Wider understanding of legislation:* The public, nursing and allied professions, and legislators should be made aware of the purpose and advantage of such legislation, namely, the protection of the public against incompetent practitioners.

*More home care:* There should be further development of organized home care services by such methods as the extension of hospital facilities into the community, visiting nursing, and housekeeping services.

*Nursing in health insurance:* There should be provision for nursing benefits in prepaid medical plans, both in voluntary medical and hospital plans, and in government health insurance plans.

*Coordination of health services:* There should be coordination of all health services, to provide for continuity of care and to prevent over-

lapping or duplication of services.

*Participation in planning:* Nurses should be consulted when health services, health units and hospitals are being planned.

*Research and pilot studies:* There should be continuous research to determine nursing needs and resources and the most effective way of utilizing nursing personnel. Increased scientific knowledge in nursing should be continually promoted. Together with research, there should be an experimental approach to the improvement of nursing service including pilot studies and demonstration units.

*Economic welfare:* The professional nurses' organization of each province should be concerned with the economic and social welfare of its members. It should act as the bargaining agent for nurses with employers on matters pertaining to conditions of work. A counselling, guidance and placement service should be maintained.

*Public relations:* An effective public relations program is essential for the nursing profession, both internally and externally. Nurses must know and accept their responsibility in providing the quality of nursing service needed. A continuing flow of information should be designed to help create public understanding of nurses as a group capable of taking their part in planning and providing essential health services.

#### THE NEEDS OF NURSING EDUCATION

*Education for service:* The philosophy of nursing education must be re-examined and restated in the light of the nursing needs of society. Nursing personnel required to meet these needs must be determined, and effective curricula constructed to prepare such personnel.

*Independent schools:* The education of nurses should be placed within the general educational system with the same financial support as that afforded other professional education. Close association must remain with the hospitals and health agencies where clinical experience is provided, but schools of nursing should be educationally and financially independent.

*Individual development:* Basic nursing education should foster the de-

velopment of a mature individual, able to work alone or with others in providing a high quality of nursing service and able to take her place on the health team in planning and coordinating health services.

*Broader curriculum:* Learning experiences and teaching methods should be designed to help the student develop skills in human relations, leadership and teaching. The student should be prepared to evaluate a situation and to be creative in solving problems. She should be prepared to employ good judgment in making decisions and to act in a purposeful manner.

*Flexible curriculum:* The curriculum should be flexible enough to permit adjustments to the needs of individual students. Teaching methods and learning experiences should focus attention on the patient. Every student should be given the opportunity and time to work constructively with her patients.

*Integrated curriculum:* The principles of mental health, nutrition and public health should be integrated throughout the basic curriculum.

*Advanced graduate studies:* If the quality of nursing service envisaged is to develop, the present registered nurse must be helped to acquire additional skills, understanding and knowledge. Educational programs should be further developed to meet the need of graduate nurses for advanced preparation. Bursaries, scholarships and fellowships should be available to enable nurses to take advantage of post-basic and postgraduate educational programs. Regional conferences, seminars, institutes and refresher courses should also be utilized.

*Mental health understanding:* To work effectively with people, sick and well, and to participate more effectively in the field of mental health, nurses must have a better understanding of human behavior and basic emotional needs. They must be able to recognize early symptoms of tension, fear and anxiety and to develop the necessary skills in helping people identify and evaluate their own problems. They must also be able to interpret mental health services available in the community.

*Mental health specialization:* Post-



basic educational programs for graduates of hospital schools of nursing are required if nurses are to achieve a better understanding of mental illness and their role in its prevention and in the treatment and rehabilitation of the mentally ill. These programs should be conducted under the supervision of recognized educational institutions and include satisfactory clinical experience.

**Accreditation of schools:** A national plan for the evaluation and accreditation of schools of nursing should be established under the jurisdiction of the professional nurses' organization.

**Public education:** An information program is needed to create greater public awareness of nursing as an essential public service requiring public support for its educational needs.

## Convention Personality

**Byrne Hope Sanders, C.B.E.**, who will deliver the Mary Agnes Snively Memorial Lecture at the June convention, is vice-president of Gruneau Research Limited of Toronto, Montreal and New York. She is a co-director with her brother, Wilfrid Sanders, of the Canadian Institute of Public Opinion (Gallup Poll).



(Paul Rockett)

### BYRNE HOPE SANDERS

For many years Miss Sanders was editor of *Chatelaine* having been with that publication since its inception. She was called to Ottawa at the beginning of World War II, on loan to the Government, as director of the Consumer Branch, War Time Prices and Trade Board. For six years, while still

retaining her association with *Chatelaine*, she organized and worked with the women of Canada in helping to achieve the remarkable success of the nation's price control policy. Sixteen thousand officers, all voluntary workers, worked with her Department throughout the war. She was honored when she was made a Commander of the Order of the British Empire for her valuable war services.

In 1951, Miss Sanders resigned as editor of *Chatelaine* to go into partnership in Market Research with her brother. In April, 1955 she became vice-president and director of Gruneau Research when the two research agencies merged.

As the only woman member of Canada's Dollar Sterling Trade Board Miss Sanders is one of a group of industrial executives, under the chairmanship of Mr. J. S. Duncan, President of the Massey Harris Company, who work with the Dollar Export Board of Great Britain in developing trade between the two countries.

One of Miss Sander's special concerns in her work with Gruneau is a panel of 5,500 Canadian home-makers who report each month on household purchases. This panel gives an accurate picture of Canadian buying habits in the home and is an important part of Canadian business life. She is the author of two books "Emily Murphy, Crusader" published by Macmillan's and, in cooperation with Miss Margaret Aitken, M.P., of "Hey Ma! I Did It," the story of Miss Aitken's election to the Federal House.

In private life she is Mrs. Frank Sperry. The Sperry's have a son and a daughter, aged 19 and 21 respectively.

You are growing old gracefully if you are beginning to realize that other people are right a good part of the time.

You can accomplish anything if you have patience. You can even carry water in a sieve — if you wait until it freezes.



# NURSING SERVICE

## A Child with Laryngotracheo Bronchitis

SISTER MARY ANN CECELIA, S.S.A.

**J**IMMY, AN INDIAN LAD of 2½ years suffering from acute laryngotracheo bronchitis, is the hero of this case study. His progress from an acutely ill boy to a well child fascinated me. The conviction that good nursing care played a most important part in his return to health was the primary factor influencing my choice of his case for my study. Furthermore, Jimmy afforded me my first practical experience in the care of a patient with a tracheotomy tube.

Because I was his special nurse for a short time during the acute stage I am confident that, in the future, I could efficiently and calmly help other children in similar distress. Yes, I owe much to Jimmy and it is a pleasant duty to write about him.

### SOCIAL BACKGROUND

*Environment:* Little Jimmy's home was one in which the elements of sanitation and hygiene were not considered. He arrived at the hospital dirty and infected with pediculi. His parents did, however, satisfy his fundamental need to be loved and to feel secure. He was totally unspoiled by his home and social environment. Therefore, his personality was developing naturally and normally.

*Race:* Jimmy was a typical example of the Indian race, with his brown skin, coarse straight black hair, wide-set cheek bones and brown eyes.

*Religion:* With their Roman Cath-

olic faith as a basis, Jimmy's parents knew their tremendous responsibility towards him so they had taken the fundamental steps to ensure his spiritual progress. It was interesting to note that whereas many children of the white race have little spiritually, but much physically, mentally, socially and emotionally, Jimmy's training was in reverse order.

### MEDICAL BACKGROUND

*Past Health:* Jimmy was well until he had broncho-pneumonia when eight months old. This condition necessitated hospitalization. X-ray of the chest showed increased markings of both lungs. With antibiotic therapy (penicillin) his symptoms subsided within three weeks. Jimmy's general condition improved and he was discharged from hospital to continue his convalescence at home.

*Present Illness:* Jimmy had been suffering from respiratory embarrassment, croupy cough, hoarseness, and fever. The doctor diagnosed this acute respiratory infection as laryngo bronchitis.

### LARYNGOTRACHEO BRONCHITIS

The characteristic lesion is an inflammatory edema of the subglottic tissue associated with inflammation of the larynx, trachea and bronchi. This condition presumably results from infection caused by the virus of the common cold. Hemolytic streptococci, influenza bacilli and pneumococci at times appear to be responsible, but frequently no bacteria other than those normally expected in the pharynx can be isolated. The disease appears to depend more upon the low resistance

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Sister Mary Ann Cecelia is a second year student at St. Joseph's Hospital, Victoria, B.C. This study was awarded the first prize by the Macmillan Company of Canada Ltd., in the 1955 competition.

of the individual than upon the specific infecting agent. It is much more common in infancy and early childhood than at later ages. The reason for this is that the larynx in infancy differs in some respects from that of later childhood and adult life. The upper portion is relatively narrower laterally, the cartilages are softer, the walls are more readily compressible and the mucous membranes are said to be more vascular. These anatomical peculiarities render the infant's larynx susceptible to obstructive lesions.

It may be of interest to note that in a series of 297 cases of acute laryngotracheo bronchitis 70 per cent occurred in boys. Of the total number, 88 per cent were treated without tracheotomy and, by that criterion, might be classed as mild cases.

## SIGNS AND SYMPTOMS

### *Common Symptoms*

1. Hoarseness and a barking cough which may be hard and teasing, often worse at night.
2. Intense inflammatory edema of the respiratory passages, particularly of the subglottic tissues, producing obstruction of respiration.
3. The inflammatory exudate is a major cause of symptoms. It is so thick and viscous that it cannot be coughed up. The normal reflex for cough is stimulated by movement for foreign material in the respiratory tract. If the exudate is too thick to move, no cough occurs.
4. Respiratory obstruction may occur from accumulation of the exudate. A large bronchus may become plugged with exudate, resulting in atelectasis of the part of the lung supplied by that bronchus. Dyspnea and cyanosis result.
5. Struggle for air becomes ominous and unremitting. Tracheotomy may be life-saving.

### *Jimmy's Symptoms*

1. The first five days he had a severe nocturnal croupy cough which later developed during the day also.
2. There was marked respiratory embarrassment and hoarseness together with a croupy cough. His larynx was very edematous as seen by the difficulty experienced in passing the anesthetic tube through it for the tracheotomy.
3. In spite of Jimmy's harsh, croupy cough

no exudate was coughed up because it was too thick and viscous.

4. The night of admission, the nurse noticed that, in spite of humidified oxygen therapy, the child's face was quite cyanotic, respirations were labored, harsh sounds were produced in inspiration. Jimmy was very restless. Both the edema and the accumulation of exudate were causing respiratory obstruction. During the bronchoscopy done the next day a large amount of bloody mucous was aspirated.
5. The severity of our little patient's respiratory distress, increasing dyspnea, restlessness, and pulse rate indicated a progressive obstruction to the airway, clearly calling for a tracheotomy.

## MENTAL ASPECT OF HOSPITALIZATION

Hospitalization for Jimmy meant separation from Mommy and Daddy as well as many fear-provoking experiences such as:

being placed in an oxygen tent, receiving hyps and intramuscular injections, seeing the nurse suction his tracheotomy tube with an electric machine.

Jimmy's difficulty in breathing, however, was the prime cause of his anxiety at the time of his admission. The nurse, realizing she was nursing a child and not a disease, was quickly attuned to the feelings he could not describe and used all her creativeness to allay the fears he was unable to express. She stayed by his bedside continually to meet his every need. Thus, our little Indian lad found trust, confidence, reassurance and affection in his nurses. Fine cooperation was the outcome of this ideal relationship between nurse and patient. Whether it was a hypo or the suction machine, little Jimmy felt quite secure because his favorite nurse was "an angel by his bedside."

It was not until the fourth day of his hospitalization that Jimmy showed signs of loneliness. It may be of interest to note here that he was now feeling much better. All respiratory distress had disappeared. At this phase the thought of Mommy and Daddy could have first place in his little mind. Toys were now given to him to keep his mind occupied. The nurse chatted with her young patient, brought him to



the window to see the trees, the grass, the sky, the cars and the children playing outside. Jimmy felt someone cared for him. That was all a two-year-old needed to be mentally alert, happy and secure.

#### GROWTH AND DEVELOPMENT

Little Jimmy was physically, mentally, socially and emotionally comparable to a normal child of his own age. He weighed 33 pounds and was 36 inches long. When convalescing he was a "run-about," staggering in his steps. He delighted in taking things out and putting them back. He was capable of feeding himself and generally did so rather neatly. His short sentences as well as single words were very intelligible, i.e., "Dis is mine." Nursery rhymes, however, were totally unknown to him.

He was proud of flashing his teeth in a big smile and he put them to good service in masticating his food correctly. His parents had succeeded in teaching him bowel and bladder control. On the whole our little patient was totally unspoiled and like all children of two years, he had only two great loves . . . Mommy and Daddy.

#### MEDICAL TREATMENT

1. *Penicillin*, an antibiotic which harms or destroys microorganisms. It is derived from a species of molds belonging to the genus *peni cillium*. It may be administered intravenously, intramuscularly or intrathecally, orally, locally or by inhalation. It is remarkably toxic-free although sensitivity phenomena have occurred. Jimmy received 600,000 units daily.

2. *Alevaire*, an aqueous solution of a new nontoxic detergent, oxyethylated tertiary octylphenolformaldehyde polymer 0.125% in combination with sodium bicarbonate 2% and glycerin 5%. This mucolytic detergent is administered as a fine mist by aerosol nebulization utilizing a suitable supply of oxygen or compressed air. Usual dose: 500 c.c. by aerosolization in 24 hours. The doctor ordered the usual dose for Jimmy, utilizing the supply of oxygen of the croupette to liquify secretions produced.

3. *Nembutal* or pentobarbital so-

dium is an hypnotic producing a condition resembling natural sleep. It is comparatively safe in acute laryngo-tracheo bronchitis since there is not much effect on the circulation or respiration. Half grain suppositories were ordered.

4. *Calcium gluconate*, more palatable than calcium chloride for oral use, is given to relieve a deficiency of calcium and, therefore, to prevent tetany and rickets. A half tablet was given t.i.d.

5. *Fer-in-sol* is an iron preparation often used in secondary anemia. Its administration over a period of time causes an increase in the red cells and hemoglobin. The patient becomes more energetic and has a better appetite.

Constipation is a common result of long-continued use of iron preparation. Iron is absorbed slowly and incompletely from the intestines. It is well to remember that iron, as well as any other metal will dissolve vitamin C preparations, therefore, these medications should not be administered at the same time.

6. *Vitamins*: The chief function of vitamins is to take part in essential enzyme reactions within the cells and thus to maintain normal growth and metabolism. Deficiency of a single vitamin may produce symptoms of some disease that can be cured by the administration of that vitamin.

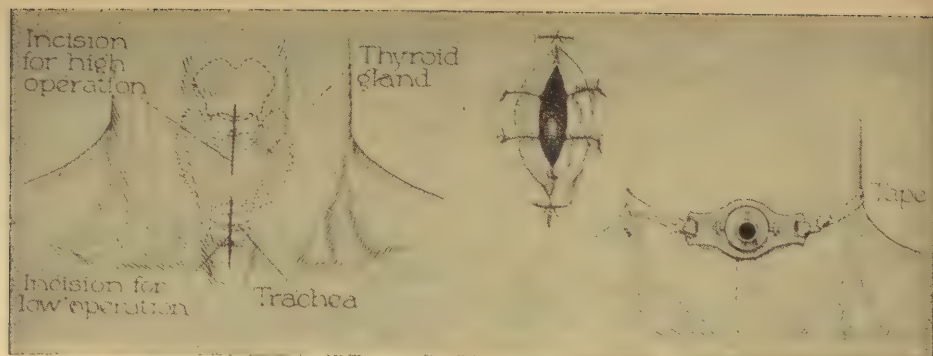
#### DIET

For the first three days, the diet consisted in forcing fluids with restriction on the amount of milk because it is mucous-forming. Regular diet was allowed on the fourth with milk restriction. In the early period following the tracheotomy Jimmy was fearful of swallowing. As soon as he realized that it caused him no added discomfort he began to take fluids and solids more eagerly.

#### SPECIAL THERAPY

*Oxygen and Alevaire*: Oxygen was administered via croupette to give immediate relief of cyanosis and dyspnea while alevaire was given to liquefy the thick secretions and make it easier for the child to cough the secretions up from the respiratory tract. Oxygen,





Surface anatomy showing relationship of high and low incisions to underlying structures.

Method of fixing trachea by through and through sutures. Method for holding tracheal tube by tape.

however, did not give the anticipated relief. There was an obstruction in Jimmy's respiratory passage which needed more than oxygen. Both the oxygen and the alevaire were discontinued immediately following the tracheotomy.

**Steam inhalation:** The inhalation of steam is considered the most valuable therapeutic measure in laryngotracheo bronchitis. Following Jimmy's tracheotomy, the steam kettle was in constant operation. High humidity at an environmental temperature of 70° F. is most beneficial. If air humidity is low, it may aggravate the disease by drying out the thick secretions and making it more difficult for the child to cough them up.

### SURGICAL TREATMENT

Increasing dyspnea, pulse rate rapid, restlessness and cyanosis in spite of humidified oxygen therapy indicated a progressive obstruction in the airway which clearly called for a tracheotomy. This was done within 12 hours of his admission.

The proximate preoperative preparation consisted in having the child void, putting on an operation suit and administering atropine gr. 1/450.

**Operation:** There was some difficulty in passing the anesthetic tube through the edematous larynx. After this was accomplished and Jimmy was sound asleep, the trachea was opened by means of a midline incision and a tube was inserted into the lumen of his trachea. This enabled him to breathe more easily.

A bronchoscopy was also performed

at this time. By introducing the bronchoscope into the trachea it was possible to study the mucosal lining of the trachea and the larger bronchi. A good deal of bloody mucus was aspirated. The wall of the trachea and bronchi were quite red. After fixing the sides of the trachea with sutures a number three tracheotomy tube was inserted as the anesthetic tube was withdrawn. The accompanying illustrations may prove both useful and informative.

### POSTOPERATIVE CARE

Following the tracheotomy these important procedures were carried out:

Jimmy was placed in a warm bed to prevent chilling.

Arm restraints were immediately applied to prevent the patient from removing the tracheotomy tube.

Suction machine was kept at bedside to suction the inner cannula as often as necessary.

Steam kettle was in constant operation.

Special nursing care, day and night, was required until the tracheotomy tube was removed. Symptoms of suffocation had to be watched for. These might occur at any time from the plugging of the bronchi or from the blocking of the tracheotomy tube. Aspiration of the secretions well down into the trachea through the tube was done very often the first two days. On the third day the need for suctioning decreased. The type, amount, color, and odor of the material suctioned was charted accurately. The secretions varied from thick dark green with mucus to colorless viscous material.

The inner cannula was changed every two hours for the first twenty-four hours; then every six hours, according to the doctor's order.

Before removing the tracheotomy tube on the sixth day postoperative the doctor inserted a plug which the nurse was to remove if Jimmy became distressed and started to struggle for breath. After the first few minutes Jimmy was a bit frightened. He started to cough and gasp. The plug was removed and a large amount of white mucus was expectorated. Later the plug was re-inserted. This enabled the child to speak. His voice was still hoarse, but he really enjoyed talking. He gradually became used to the "plugged tracheotomy."

The doctor returned in the evening of the same day to remove the inner and outer cannulas. The area of incision was cleansed with ether. Sterile dressings were then applied with elastoplast. Dressings were changed frequently because they were soiled with mucus.

On the following day, the sutures were removed and a clean dressing was applied. The incision was cleansed p.r.n. with zephiran chloride solution 1:1000. We were all proud and happy to see that Jimmy's incision was surgically clean and healing well.

Thirteen days later Jimmy was allowed up. His cough had improved and his appetite was marvelous. He played well and seemed very happy. Soon he was strong enough to be discharged. After 25 days of hospitalization it was a real treat for Jimmy to go back home to his Mommy and Daddy.

## NURSING CARE

### 1. *Personal hygiene:*

*Care of hair and scalp:* Jimmy's hair was not washed upon admission because his condition was so acute. Pediculi were soon discovered and, upon the doctor's order, treatment was given with a solution that was destructive to the lice and nits but harmless to the hair and scalp. It was applied to Jimmy's scalp with gauze sponges. Care was taken that the solution did not get into his eyes. Head covering was then applied and left for one hour. His head was then washed and fine-



*Suctioning the tube*

combed. No live pediculi were found following this treatment.

*Skin:* It is imperative to keep the skin in good condition. A tub bath was given to Jimmy as soon as his condition warranted it. Daily sponges were given during his acutely ill phase. On the first few days when perspiration was profuse, several sponges were given daily. Special attention was given to all the body creases as well as to the back and buttocks.

After Jimmy's operation, the skin around the opening became irritated from the secretions. Jelonet dressings were changed daily and the skin cleansed with zephiran chloride 1:1000. Jimmy's finger nails were cut as well as his toe nails and they were kept clean at all times. His position was changed frequently to prevent pressure sores as well as hypostatic pneumonia.

*Mouth and lips:* Mouth hygiene is extremely important. Jimmy was able to take fluids which prevented oral dehydration. Daily saline mouth washes were given during his acute stage.

*Nose and ears:* Jimmy's nose was cleansed frequently with applicators because of moderate nasal discharge: His ears were also cleansed daily with applicators moistened with normal saline.

2. *Intake and output:* Small amounts of fluid were often offered and taken. Record was kept as to whether or not he was voiding a sufficient quantity. The doctor did not require an exact account of the child's intake and output.

3. *Elimination:* Although Jimmy was voiding in sufficient amounts and



was having daily bowel movements, it was impossible during this acutely ill stage to carry on habits that he had already acquired at home. His physical condition lowered his ability to use self-control and interfered with any definite plan for toilet habits. Later, during the convalescent stage established toilet habits were resumed.

4. *Sleep*: Sleep is a matter of the greatest importance to the mental and physical health of a child, especially during the first three years. This is true of a healthy child and most true for a sick boy or girl whose body needs extra energy for repair work.

The nurse provided conditions that allowed Jimmy to have at least eleven hours of undisturbed sleep at night with a two-hour nap after the midday meal. When he was too restless at night to sleep, he was given a suppository of nembutal gr.  $\frac{1}{2}$  as ordered.

5. *Diversional Therapy*: During the acutely ill phase there was no time for loneliness or monotony. The continual presence of a nurse at his bedside with much to do for him day and night, provided ample distraction. Furthermore, the nurse recognized and understood the fundamental social, emotional needs of the child. She did make adequate provisions for meeting his six great needs, which are: his need for affection, for belonging (security), for self-esteem, for social approval, for achievement, and for independence. The result was a happy and cooperative little patient. When

convalescing, he was given toys to play with and was allowed to get up and amuse himself with the other children in the ward. He enjoyed this very much.

6. *Prevention of infection*: Even though the dangers of respiratory obstruction were successfully met, every precaution was taken to prevent further infection which would not only retard repair and growth of body tissues but could also lead to death. Efficient and observant nursing care which avoided draughts, cross-infection and poor technique had a great role in preventing sepsis.

#### PARENT EDUCATION

Tactfully and kindly, the following were pointed out to Jimmy's mother:

1. The importance of a regular annual medical examination.
2. The necessity of dental treatment now that the child is two years old.
3. The vital need of general hygiene.
  - a. Daily bath for the youngster.
  - b. Hair kept short and washed frequently. Use of fine comb.
  - c. Clean clothing including underwear.
  - d. Dental attention especially following meals.
  - e. Cleanliness of hands before meals and after toilet use.
4. The importance of vitamins were stressed.
5. The basic food rules were emphasized.

## Official Notice - 28th Biennial Meeting

The Twenty-Eighth Biennial Meeting of the Canadian Nurses' Association will be held in the University of Manitoba, Winnipeg, Manitoba, June 25th to 29th inclusive, 1956.

The President of the Canadian Nurses' Association has asked me to

advise you that there will be a meeting of the Executive Committee, Sunday, June 24th, at 10.00 a.m. at the University of Manitoba.

M. PEARL STIVER,  
*General Secretary.*

The obstetrician who claimed never to have lost a father was luckier than he knew. Now that maternal mortality rates have dropped so drastically, fathers seem to be receiving more attention. Fathers-to-be today

are being encouraged to attend natural childbirth classes and births. If the husband can be present during labor and at birth much less tension results for both husband and wife. — COMMUNICATIONS ASSOCIATES, INC.



# NURSING EDUCATION

## Some Considerations on the Basic Nursing Curriculum

G. B. CARTER

NOT LONG AGO the words "nurse" and "nursing" conveyed to most people, no less than to nurses themselves, the idea of attention to persons unlucky enough to have to take to their beds. Florence Nightingale's flash of prophetic insight "hospitals are not enough" went unheeded, so great was the pride of skill and achievement experienced by doctors and nurses in that wonderful epoch dominated by the researches of Pasteur and Lister and the advent of anesthesia.

It was true surgery could not do everything. An English surgeon wrote "thirty-five years ago, all the beds in the Cancer Wing of the Middlesex Hospital were occupied by inoperable cases of cancer; there was no treatment except an almost superhuman kindness."

Now, slowly, perhaps unwillingly, for superhuman kindness may be easier to practice than that imaginative insight into the total circumstances of

a human being, mental, physical and social which is alone able to teach him to achieve his potential of health and to restore it when lost, we are learning that the objective of nursing is health, not sickness. Sickness is incidental, health an aspect of the whole personality. Health has always been a preoccupation of the community for unless its vital statistics are sound, the community, whether it be the family or the State, perishes. But the community has not always known how to get health. Only slowly has it dawned that, although you may have categories of personnel specialized to undertake different activities in cure and prevention, it is only when these are all dominated by the conception of health that disease begins to lose its hold. Of patients with tuberculosis, some may die (and what nursing they will need!) but it is certain that more will live if, in all her cases, the nurse fixes her mind on a living person restored to the community, his children and workmates taught how to live free from infection.

In the light of these remarks, two points seem to arise and the answers to the questionnaire show that the schools of nursing are well aware of them. The first is that the nursing profession has to assume responsibility for health and this involves a basic curriculum to teach the student nurse to integrate the idea of health in all that she learns to do for patients. From this, it follows that she must be aware

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Miss Carter, who is a Nursing Consultant with World Health Organization, spent some years on the faculty of the School of Nursing, University of Toronto. At present she is in the Department of Public Health and Social Medicine, University of Edinburgh.

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This paper is published with the permission of WHO. The questionnaire referred to was sent to each participant in the Conference on basic nursing. Nine European countries were represented.

of the mental and social circumstances of her patient as well as of his bodily needs. From the practical point of view, it means that the nursing profession can no longer afford a stereotyped training based on an outdated conception called "general nursing," but must fit its members to deal with the actual maladies and needs of the society in which they practise. If many individuals are sick in mind, it is the duty of nurses to turn to the nursing of the mentally ill. This is not easy. It involves a fresh look at those who offer themselves as nurses, and the way they should be taught. The foundation of a basic curriculum needs continuous research and flexibility, and perhaps willingness to give up dearly loved traditions, to recognize rationalization masquerading as fundamental truth.

The second point is that the nursing profession, if it is to fulfil its obligation to meet all needs for nursing, must have the help of the State. It is remarkable that new surveys of nursing are being made and new laws passed in every country. In Britain, for instance, the first Nurses' Act was passed in 1919 and there was no amending Act for nearly 25 years. Acts were passed in 1943 and 1949 and no doubt there are more to come. An aspect of this interest of governments in nursing is the increasing part played by Ministries of Education. It hardly seems in doubt that if the education of nurses is basic to the health services of a country nursing education must be part of the general educational facilities provided by the State, although it is equally true that nurses themselves and the health authorities must have a clear conception of what nurses need to know. In those countries where a national health service is offered and in which, therefore, nurses have become servants of the State, employed by the Ministry of Health, it is particularly desirable that the education authority and not the employer should be responsible for the education of students and also for post-basic education in whatever type of institution it may be carried out. Of necessity all nurses must be educationists. No branch of the health service — not even the doctors, could have such a continuous and vital con-

tact with patients, ill and well, and it should be an obligation of the basic curriculum to teach nurses how to teach their patients, not only by example, but to be able to give them simple words of explanation and encouragement.

But governments do not legislate until public opinion is ready. Hence it is a duty of the nursing profession to educate and inform public opinion, using all the means they have, including the enlightenment of the members who represent them in Parliament. Much criticism of nurses and nursing is ill-informed and rarely do nurses know how to answer their critics effectively, or even to state their aims convincingly. It may be that this is a question of postbasic teaching, but even a basic curriculum needs to make students aware that they are public servants. One duty of a good servant is to keep his master informed.

It follows from what has been said that since health is the concern of every member of the community, since all men are patients from one point of view or another, such a wide field of employment cannot be covered by one group of nursing personnel only. In the the past nursing has been done by a professional group, who the First Expert Committee on Nursing called "nurses who supply the most exacting, comprehensive responsible care of a nursing nature." The service of professional nurses has never more than partially met the demand for nursing. Often it has been too expensive for many who need it most. It has been supplemented by the work of unofficial, unrecognized, devoted, but often untrained persons, called variously practical nurses, assistant nurses, etc. Very unwillingly have the professional nurses been prepared to admit this personnel, still less to assume responsibility for them. But if the whole field of nursing is the concern of the nursing profession it is the duty of the profession to secure for patients all the care they need. This point seems to be well recognized in every country.

The replies to the questionnaire show that auxiliary nursing personnel is extensively employed and in most countries their training and official recognition is under consideration. The provision of a number of types of nurs-



ing personnel under the direction of the professional nurse points to the need for curriculum research and for flexibility. The Second and Third Expert Committees on Nursing declared that the art of supervision of auxiliary personnel must be taught in the basic curriculum of the professional nurse. As the allocation of skills and duties respectively to doctors and nurses has changed and is constantly changing, so the relationship of the professional nurse to the other members of the nursing team must be kept constantly under review. This is a matter which may be agreed in principle by nurses as an international profession, but each country has to survey its own resources of men and women, the tasks to be accomplished and the personnel available to perform them, having regard to the level of education and intelligence of those who offer themselves for nursing. There can be no hard and fast rules as to the duties performed by each category. Where, for instance, there is a high proportion of doctors they are likely to undertake procedures which nurses do in countries where doctors are few. The important point is that no one shall assume a duty without learning the skill to perform it.

One of the results of the enormous growth of hospitalization and the curative services has been the metamorphosis of the independent school of nursing as envisaged by Florence Nightingale into the hospital school lacking independent, financial and educational resources. It is impossible to acquit nurses themselves of lack of vision and clear purpose in permitting this transformation, however heavily the odds have been against them.

The Nightingale probationer, even if an apprentice, was truly a student during her year of training. In 1860, public education was still to come and many of the probationers had little learning. The methods of education devised at St. Thomas's fitted the new nursing group. Those of good education assumed a responsibility for helping those with little, thus getting practice in teaching and demonstration. It must also be remembered that the able, educated women quickly as-

sumed positions of great responsibility.

Today we have stereotyped training. The evergrowing need of the hospitals for staff and the high wastage of students, never properly understood or investigated, brought about perhaps the most thorough exploitation of a group of workers that has ever been seen. Nurses themselves, the doctors and the public have all conspired to use student nurses as employees. What is worse this usage has been rationalized, until a girl wishing to nurse, whatever her capacity, intelligence and education is compelled to undergo a lengthy period of training based on tradition and the desire for labor and not on any scientific determination of the time necessary for adequate preparation for the responsibilities to be assumed. Nor have the hospital schools known how to make the best use of their qualified nurses. All too often staff nurses and head nurses have been given positions for which their apprenticeship training has not really fitted them. It is tempting to ask whether some of the difficulties now confronting the nursing profession may not be due to a steady tendency to select for promotion the student able to stand up to the perpetual rush in a busy hospital and to get the work finished, rather than the thoughtful, sensitive, educated woman, anxious to serve her patients and to know the reasons for the care she has to give. There can be little doubt that many nurses are lost to the profession from a sense of frustration and impotence rather than from any lack of love of the profession they so ardently wished to enter.

The use of the student nurse employee to do the work of the hospital has created an economic problem of the first magnitude. In the United Kingdom, it was shown in the inquiry made by the Nuffield Foundation in 1953-54 that 75 per cent of the nursing is done by nurses in training. Similar conditions are to be found in other countries and it would be helpful if analysis of the work of hospital nurses on the same lines as the Nuffield Inquiry could be repeated in other countries. It is difficult to see how this state of affairs can be ended. Two lines of approach are indicated. Nurses, in season and out of season, must



never cease to tell the public, the students and the authorities that the student of nursing should be treated like any other student and that the experience she is given must be educational.

The argument which would however do more than anything else to convince the hospital authorities, public and private, would be research demonstrating that the apprenticeship system, with its high turnover and wastage of labor is economically unsound. Nurses are beginning to turn to research and there is a wide field here. Again, methods of research are no doubt postbasic, but the basic curriculum should teach the student to be critical of her work and to see where it could be improved technically and administratively. Such criticism could be constructive and would bear fruit when students in due course become administrators and teachers, or practitioners of bedside nursing. The student nurse, understanding that she is part of a system which cannot be altered in a minute, is willing to give her service. Nonetheless, she can be shown a vision of a better way in which the patient would enjoy a service of qualified nurses and trained auxiliaries and in which the student would learn her profession in the quickest and most effective way, theory carefully coordinated with practice.

From another angle, hospital training as now given provides an inadequate preparation for the great fields of preventive and specialized nursing which are, equally with general nursing, the responsibility of the profession.

The answers to the questionnaire show that nurses are alive to this problem. So long as the labor of the student is wanted for three or four years in a general service, it is difficult to plan either a comprehensive basic training or to allow those who wish to do so to specialize whether in the hospital or in the public health field.

Many of the writers have a clear idea in their minds that to meet the needs of the profession the education of nurses must begin with a foundation or basic preparation dealing with the human individual as a person having

a mind and a body, living in a community. After laying the foundations, the student may then specialize and, finally, the leaders in teaching and administration and research must be prepared by special courses in universities or elsewhere. A point to be considered is to what extent all nursing personnel, whatever their background and education and future role, should have their first introduction to patients in common.

What has been said hitherto applies to nursing wherever it is practised. Each country however has its own problems. The international nursing profession is as strong as its weakest link. Advance in the philosophy and practice of nursing can only take place as each country identifies and solves its own nursing problem.

Identification of problems involves estimation of the needs for nursing service of all types, based on the geography, climate, health hazards, racial characteristics, vital statistics, economic resources, including available personnel and standards of education, in the particular country. At the request of the First Expert Committee on Nursing, Margaret G. Arnstein prepared a Guide for National Studies of Nursing Resources. It would be a step forward if each country were to make a study of its nursing resources to use as a blueprint for its future plans. These studies should be available to the World Health Organization and to the International Council of Nurses.

Following on such a study an appraisal of the adequacy of existing services might be undertaken — showing quality as well as quantity. No more courageous study of this kind has ever been made than the report on practices in schools of nursing in 1949 based on a survey by the Subcommittee on School Data Analysis of the National Committee for the Improvement of Nursing Services. In this survey, which was published under the title "Nursing Schools at the Mid-Century" (1950) by Margaret West and Christy Hawkins, about 97 per cent of state accredited schools of nursing giving basic programs throughout the U.S.A., cooperated and answered the questionnaire on the

educational facilities offered in each school. Based on the results classification into three groups was voluntarily accepted. This classification quickly led to self-examination in each school and to improvement in nursing education.

It is only as a result of clear-eyed, honest estimation of assets and goals that a program for an advance in the quality of nursing education can be made. Until all the facts, good and bad, are known, curriculum planning will be academic rather than practical. Nor will it be possible to implement a curriculum without an adequately prepared staff. These are two aspects of the goal of better nursing education

and each country must consider them together.

As nurses become more and more an international confraternity, ready to practise their profession wherever they may be sent, or may find themselves, the problem of reciprocity arises and requires solution. The material for solving this and many other questions of practice can only be found in accurate knowledge of the standards in each country and the quality of the basic and post-basic programs of nursing education.

1. "The work of Nurses in Hospital Wards," Report of a Job-analysis Nuffield Provincial Hospitals Trust.

## Using Case Histories to Learn

CAROL E. MOREHOUSE

**S**TUDY IS ALWAYS MORE INTERESTING when it can be related to actual experience. Often the study of anatomy and physiology seems very factual — even when pictorial, experimental, and film aids are used. In our school of nursing, however, we recently found that such learning was stimulated by the study of real people. This was accomplished by the use of medical-surgical case histories from our affiliated hospital. This method of learning was introduced into our school last year. We have found that it has helped us a great deal, and any hindrances were not too difficult to overcome with a little effort.

In order to illustrate clearly how we used these case histories, I shall describe one of our classes. Early in February last year we began study of "the means by which the body maintains an adequate and safe food supply." Our instructor gave us a case history of a young woman suffering from gallstones and cholecystitis. It consisted of a short summary of the patient's condition and her chief symptoms, together with the results of any pertinent diagnostic tests, before and after treatment.

Having read the patient's story, we were naturally curious to find out where and why her body had not carried out its normal functions properly. The class was given the choice of beginning the study at any point along the digestive tract which we desired. After some discussion and a number of ideas, we all decided that we would like to begin our study with the liver. Individual work was encouraged in our classes. In order to get some background knowledge for working, each member of the class chose one aspect of the study to read about; for example, one student studied the anatomical relationship of liver to other body organs, another the production of bile, and so on.

In the next class as each student presented her findings to the group, a more complete picture began to form. Our instructor filled in any gaps in our information, and presented the more difficult aspects of liver physiology in formal lectures.

Our laboratory periods were also useful because we performed some of the more important diagnostic tests ourselves, so that we could see the results. The tests came to mean more than just a laboratory report. We were able to do the routine blood tests, such as blood counts and the complete urinalysis examination.

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Miss Morehouse is a third year student at McMaster University School of Nursing, Hamilton.



After gathering this information together we returned to the study of the patient, whom I shall call Miss Lily. Meanwhile, one or more of the class had cared for Miss Lily as a patient, and this added to the general interest.

As we reviewed the patient's symptoms and laboratory findings, we began to look for explanations; these called on our new knowledge of liver physiology. All this, of course, was leading up to the summary, where we could see the whole picture of the ways and means by which the body preserves the normal function of the liver and gall bladder.

Thus this one case history of a person suffering from gall bladder disease helped in the learning of the normal structure and function of the gall bladder and its related organs, unfavorable influences on that normal function, relationship of the organs to the working of the human body as a unit, and their part in its intricate mechanism.

In addition to these organs alone, studying the various tests led to exploration of the effects on the liver and gall bladder of changes in other parts of the body — that is, it led to correlation of each system studied with the workings of the body as a whole.

We liked another way in which our instructor made use of case histories — as an examination aid. Using a case history on an examination similar information was given, then the questions were asked in relation to the information provided. All questions concerned normal aspects only, so that when abnormal symptoms appeared, we were asked to describe the normal manner of function. In this way, many aspects of the topic could be discussed, and correlated to the normal.

We found that studying each part of our subject in this manner contributed in a number of ways both to our interest in learning, and to our retention of the material.

It may sound as though a large amount of student preparation was required, but we did not find this to be so. An innate curiosity to find out the unknown about people, as well as the division of labor in the reference reading, led to only a moderate amount of preparation time on the part of each student. Our own participation in the presentation of material permitted us

to feel that we had some part in the learning process, stimulated an overall interest in the lesson, and, I believe, permitted the instructor to get a better idea of how the members of the class were thinking, and what we were getting out of her lectures.

With the instructor's help, we partly overcame a difficulty which presented itself in our original perusal — discrimination. Having no previous knowledge of the subject being studied, it was somewhat difficult to decide in our own minds what were the most important parts for study, as well as to know just which symptoms were abnormal and which normal. As we acquired more practice in the use of case histories, however, we gradually overcame this difficulty to a great extent.

By having the class go over the case history and decide what they needed to study, repetition was avoided — the class did not study again topics about which it might already know a great deal.

We did feel that one big advantage in this application of study to actual people, apart from the factor of interest, was that it led to better and more organized original thinking on the part of each member of our class. In consequence, any learning coming wholly or partly from our own original work was much more likely to be remembered longer than that from a series of formal lectures alone.

Also, just as students in nursing can better remember the nursing care of a disease condition if they have cared for a person suffering from its effects, so in this situation we could better remember the normal physiological functioning after we had studied the history of an actual person with a condition resulting from some deviation from that function.

In these lectures, which were preliminary to concentrated nursing practice in the hospital, we were helped to correlate the factual material to the nursing that was to come. So often it seemed that the actual nursing part of the course was far separated from the work we were doing, so that studying hospital cases in relation to the lectures helped to emphasize that all the material was necessary and useful preparation for the care of all patients.



When we did begin daily work in the hospital, the background knowledge gained through examination of these case histories stimulated us to read carefully the charts of the patients under our care, and to find out what had caused their illnesses.

While we were studying the normal characteristics of the body and its organs, case histories of disease helped to show the narrow borderline between health and illness, and some of the contributing factors to staying on the health side of the line. Studying the two in conjunction placed emphasis on the unity of the whole course, as we may tend to think of health and illness as two separate entities. In this

way we could study normal physiology while seeing at the same time just how it sometimes goes wrong.

Our class was a small one, so all of us were able to participate freely in group discussions. In larger classes the same result might be accomplished by breaking up into a number of small groups for the original work.

In conclusion, I might say that the members of my class are of the opinion that any nursing science class could make use of such medical-surgical case histories as may be available to contribute to the interest and variety of lectures in anatomy and physiology. We were enthusiastic about their use in our own classes last year.

## In Memoriam

**Gertrude Irene Anderson**, a graduate of the Massachusetts Homeopathic Hospital, Boston, died recently at Annapolis Royal, N.S. In 1917, Miss Anderson enlisted in the Queen Alexandra Imperial Nursing Service and spent the remainder World War I in the front lines of France. For a time she engaged in welfare work with the Victorian Order of Nurses in Montreal, returning to Nova Scotia in 1923 to become one of the pioneer nurses of that province's Public Health Department. She retired in 1948 but maintained an active interest in professional and community affairs.

\* \* \*

**Ethel Barclay**, a graduate of Dr. Groves Hospital, Fergus, Ontario, died on February 5, 1956, at Toronto. Miss Barclay was the first superintendent of Lord Dufferin Hospital in Orangeville and organized the first school of nursing in connection with it.

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**Florence Nightingale (Sims) Campbell**, a graduate of a New York hospital, died on February 12, 1956 at London, Ontario. Mrs. Campbell served overseas with No. 2 Canadian General Hospital during World War I. She took an active interest in professional matters organizing the home nursing classes in the schools of London, and assisting with other Red Cross activities.

\* \* \*

**Katherine Conway-Jones** died on January 21, 1956 at Steveston, B.C. Born in North Wales, she joined the Imperial Army in 1914 and served throughout the war.

Miss Conway-Jones was awarded the Royal Red Cross, first and second class, by King George V and was mentioned several times in despatches for her outstanding military service. Following her retirement from nursing in 1919, she came to Canada where her interest centred chiefly upon Red Cross activities.

\* \* \*

**Isabel Janet Dalzell**, who graduated from Toronto Western Hospital in 1923, died on January 17, 1956. Mrs. Dalzell served for many years on the teaching staff of the Toronto Hospital for Tuberculosis.

\* \* \*

**Mary Agnes Dean**, a graduate of St. Joseph's Hospital, Hamilton, died on January 25, 1956, at Hamilton. Miss Dean served as a public health nurse with the city for several years.

\* \* \*

**Doris (Trevors) Gauthier**, a graduate of the James Dunn Hospital, Bathurst, N.B., died in January, 1956 at Douglasfield, N.B.

\* \* \*

**Susan Emily Hodgins**, a graduate of the Royal Victoria Hospital, Barrie, Ont., died on January 15, 1956 at Palmerston, Ont. Miss Hodgins devoted much of her professional life to private duty nursing.

\* \* \*

**Gwendoline Jaques**, a graduate of the St. John's Hospital of the Sisters of St. John the Divine, died on January 23, 1956 at Toronto. Miss Jaques devoted most of her life to her work with the Sisters of St. John



ELIZABETH REDMOND

the Divine and other church activities. Later she had engaged in private duty nursing and was a member of the St. John Ambulance brigade serving as a nursing officer with the central nursing division.

\* \* \*

**Agnes Emily (Pederson) Lawrence**, a graduate of the Medicine Hat General Hospital, died in January, at Vancouver, B.C. Mrs. Lawrence was a former superintendent of nurses of her home school.

\* \* \*

**Robina Macaulay**, a graduate of Grace Hospital, Winnipeg, died on February 4, 1956 at Toronto. Major Macaulay served

in Salvation Army hospitals in Toronto, Halifax and Saint John. Her last post, prior to retirement, was as superintendent of Grace Hospital in Windsor, Ontario.

\* \* \*

**Elizabeth Redmond**, a graduate of St. John's General Hospital, Newfoundland, died at St. John's on November 6, 1955. She was the last remaining member of the first graduating class of the school which celebrates its golden anniversary this year. Miss Redmond came to the hospital as a nurses' aide in 1899, filled the post of superintendent of the hospital for a few months in 1902, and began her professional training in 1903 when the school of nursing was first opened. She retired from active nursing in 1930 but maintained a keen and active interest in her alumnae association. Her sense of humor, love of life and unselfish nature won her many friends.

\* \* \*

**Marie-Adrienne St-Onge**, infirmière graduée de l'Hôtel Dieu de Montréal, est décédée à l'hôpital Reine-Marie. Enrôlée comme infirmière lors de la guerre 1914-18, elle fit partie de l'hôpital stationnaire No. 4 canadienne-française. Elle fut décorée à plusieurs reprises par l'Angleterre et par la France. Elle a fondé, en 1940, l'association provinciale des infirmières de la Metropolitan Life Assurance Co.

\* \* \*

**Genevieve White**, a graduate of St. Joseph's Hospital, Glace Bay, died on February 8, 1956 at Sydney, N.S. Prior to her illness, Miss White had worked as an office nurse.

## Wanted: Your Assistance

One of our familiar nightmares concerns the problem of what we would do if anything happened to our mailing list. Very recently a minor catastrophe struck us when an overzealous janitor took away a small carton containing letters giving changes of address, the subscribers' name plates and their identification cards. It is estimated that there were between 10 and 20 subscribers' letters in the box — the changes of address that had been received on April 12.

Here is the way you can help: will you please draw the attention of any nurses

who have moved recently to these paragraphs? If they have sent us a change of address early in April, will each of these nurses please write to us again immediately, giving their old address and their new one. This information is absolutely necessary if they are to receive the May and subsequent issues.

We shall be most grateful for this assistance. The change-of-address clerk and the janitor have both given a solemn undertaking that this will never happen again, even on a Friday the 13th!



# Surgine<sup>\*</sup>

## LINEN SAVERS

— another Johnson & Johnson "FIRST"

- non-woven fabric cover
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- lowest "cost in use" pad ever offered

AVAILABLE THROUGH YOUR DEALER

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Made in Canada





# Nursing across the nation



prepared by your national office Canadian Nurses' Association, Ottawa

## CNA Submission

AMONG THE BRIEFS presented to the Royal Commission on the Economic Future of Canada at the Public Hearing in Ottawa in March, was one from the Canadian Nurses' Association. This brief covers a span of 50 years. Beginning with nursing as it was 25 years ago, dealing with it as we see it today and estimating what will be needed in the future, 25 years hence, the submission referred to studies such as the Weir Report, the Metropolitan School of Nursing experimental program and the more recent Atkinson School of Nursing experiment at the Toronto Western Hospital.

Members of our delegation were, the president, Miss Gladys J. Sharpe; our general secretary, Miss M. Pearl Stiver, and Miss Dorothy Percy, chief nursing consultant, Department of National Health and Welfare, who had been requested by the Executive Committee to assist the staff of National Office in the preparation of the brief.

The address given in presenting the brief referred to the great increase in the number of registered nurses now employed in hospitals. In the last 25 years the number of registered nurses in Canada has trebled and the number employed in hospitals is 10 times as great. This increase signifies a higher standard of nursing care to the sick. Hospitals now provide professional nursing service where previously the nursing care was almost wholly provided by student nurses.

In considering the demands for nurses in the expanding health programs for an increasing population we are faced with the questions —

1. Where can we find sufficient numbers of nurses?

2. How can we be sure that they will be equipped to give the best possible nursing service to our Canadian people

and also beyond our shores in international health programs?

Concern was expressed with the small percentage of students completing high school. Encouragement of students and assistance available to continue high school would provide a larger pool from which to draw recruits for the nursing profession as well as for other professions. That more and more nurses will be required as Canada's health programs develop is foretold in the ratio of nurses to the population over the past 25 years.

In 1931 there was one nurse to 576 persons in our population and unemployment among nurses.

Today there is one nurse in every 286 persons and we need more nurses.

Major needs in nursing with respect to the economic future of Canada were listed as:

### *Need for research to determine —*

What are the needs with respect to nursing in the present and future health programs for our people?

What personnel will be required?

What are the best and most economical ways of preparing the necessary personnel?

The suitability of our present programs and the need for evaluation in the light of present developments and progress of medical science.

### *Need for financial assistance —*

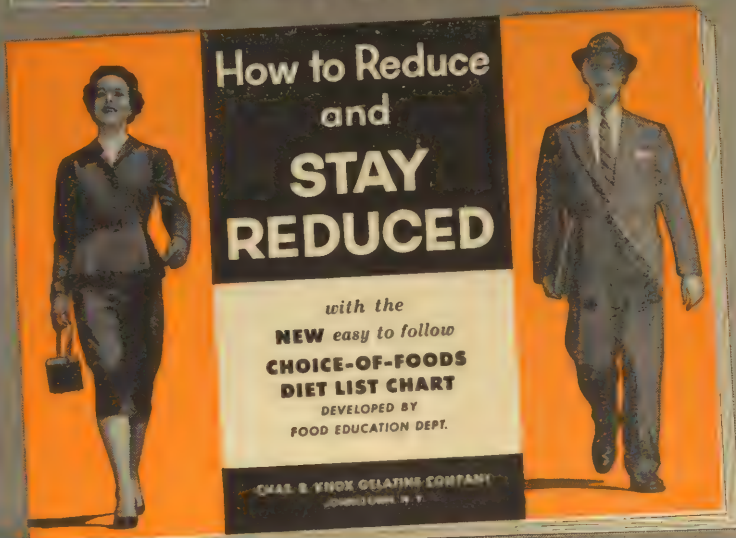
To obtain and prepare people to do this research and for the research itself.

To support a truly educational program of nursing, qualified students wishing to enter schools of nursing should not be hampered by insufficient funds. Bursaries and scholarships should be provided to enable students to pursue nursing as a career.

To enable nurses, having the qualifications to assume positions of leadership, to take the necessary advanced preparation.

**KNOX**

# Protein Previews



## New Booklet Available to Aid Management of Overweight Patients



The 1955 edition of the well-known Knox "Eat-and-Reduce" booklet eliminates calorie counting for obese patients under your care. This year's edition is based on the use of Food Exchange Lists<sup>1</sup> which have proved so accurate in the dietary management of diabetics.

The first 18 pages of the new booklet present in simple terms key information on the use of Food Exchanges (referred to in the book as Choices). In the center, double gatefold pages outline color-coded diets of 1200, 1600, and 1800 calories based on the Food Exchanges.

To help patients persevere in their reducing plans, the last 14 pages of the new Knox booklet are devoted to more

than six dozen, *tested*, low-calorie recipes. Use the coupon below to obtain copies of the new "Eat-and-Reduce" booklet.

1. Developed by the U.S. Public Health Service assisted by committees of The American Diabetes Association, Inc. and The American Dietetic Association.

Knox Gelatine Limited  
Johnstown, N. Y., Dept. CD-17  
Please send me        copies of the new  
illustrated Knox "Eat-and-Reduce"  
booklet based on Food Exchanges.  
YOUR NAME AND ADDRESS

## *A Professional Experience*

As we write this column a poster is just coming off the press which highlights the program and plans for the 28th Biennial Meeting. As you read this you will probably already have become familiar with this poster and with its message, which we hope has been displayed on bulletin boards in your hospital or health agency.

Additional to the information which it contains is the announcement of our speaker for the Mary Agnes Snively Memorial Lecture. **Byrne Hope Sanders, C.B.E.**, co-owner and director, Canadian Institute of Public Opinion, will deliver the address honoring the founder of the Canadian Nurses' Association. An excellent speaker and an interesting person, our guest speaker is one you will want to hear.

Shall we see you in Winnipeg? We hope so. If you haven't already pre-registered do so now, using the page from this issue.

## *Let's Look at Accreditation*

If you wish to participate to the fullest extent in the discussions during Nursing Education day at the 28th Biennial Meeting in Winnipeg some reference reading is in order. The CNA Executive and Committee on Nursing Education are going to ask you to think seriously about our responsibility in regard to establishing some method of evaluating Canadian schools of nursing. Perhaps a program of accreditation is the answer. In 1950 a series of articles appeared in *The Canadian Nurse* containing information which should be familiar to all those who will be asked to state an opinion. So, will you pick out the following issues and refresh your memory on some of the principles of evaluation and accreditation:

February, page 112; March, page 187;  
April, page 278; June, page 460; Oc-  
tober, page 819.

## *Canadian Nurses in Ceylon*

It is obvious that our nurses who join international health agencies do not forget about us. National Office is frequently called upon to supply prin-

ted material and other information which nurses with WHO and the Colombo Plan know will help them to develop their programs in countries less privileged than ours. Our latest request came from Eleanor Martin and Frances Ferguson who are with the Colombo Plan in Ceylon and are working to establish a school for auxiliary nursing personnel. The government had asked them to obtain a list of textbooks commonly used in Canadian schools for professional nurses and nursing assistants. In the process of collecting the information requested we found two book lists which may be of value to our readers.

The Chicago Medical Book Company, Jackson and Honore Streets, Chicago 12, Illinois, publishes a comprehensive catalogue of nursing textbooks with the dates of publication and the names of the publishing companies. A similar listing is distributed by Stacey's, 551 Market St., San Francisco 5, California.

## *Visitors to National Office*

We were pleased, in February, to welcome Miss E. Kathleen Russell to Ottawa and to CNA Headquarters. Presently engaged in a survey of nursing education in the province of New Brunswick, Miss Russell brought enthusiasm and enlightened thinking to discussions on nursing, as always.

Soon to visit us will be Miss Mavis L. Avery, general secretary, Royal Australian Nursing Federation. Miss Avery has been in Canada since early February when she arrived in Vancouver. Following a trip across the country she has spent a short time in Toronto. From Ottawa she will proceed to Montreal. Having been awarded a WHO Fellowship, Miss Avery will then sail for Great Britain, returning later in the year to the United States where she will continue her study and travels.

## *Questions and Answers*

Here in National Office we are frequently asked question for which we do not have the answers. We cannot have the answers until each one of you helps us. Statistical information which we have comes from various sources, C.N.A. records, 1951 Census, Vital



## **NEW! HEINZ STRAINED APPLE JUICE**

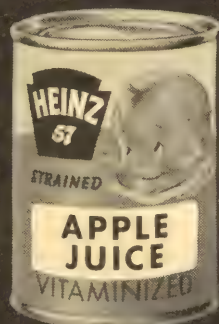


*Photograph courtesy of B.C. TREE FRUITS Limited*

### **AN EXCELLENT SOURCE OF VITAMIN 'C' FOR BABIES!**

For the mothers of young babies, the introduction of this completely new fortified apple juice is welcome news. Heinz have produced this new source of ascorbic acid in response to many enquiries from doctors. It will be found especially useful where the infant shows intolerance to other juices. In such cases, the baby can often take apple juice, for it is a food that should not disturb the most delicate infant.

Heinz Strained Apple Juice is made from only the finest apples, specially processed for babies and fortified with a minimum of 60 mgms. Vitamin 'C' per 100 cc's. If you would like to taste and test this new product, write for free samples, to Heinz Baby Foods, Leamington, Ontario.



## **HEINZ BABY FOODS**

Statistics 1953, Hospital, Tuberculosis and Mental Health Statistics 1954, and other data. It is realized that the sources of this information are not always completely accurate and much information is still lacking. A questionnaire is now being developed concerning the estimated demand for nursing in Canada. This, having been discussed with our provincial secretaries in February, will be ready for distribution through provincial associations by next September. In order that this questionnaire be successful we will need the assistance and co-operation of each Canadian nurse. Successful completion of this questionnaire will mean accurate and interesting information available from this office. Information which is essential if we hope to be able to intelligently interpret our needs to our profession and

to the public who can assist us in finding ways and means of meeting the increasing demands being made upon us.

### *A Word of Thanks*

As national committees prepare to wind up the work of the biennium let us take a few minutes to express our appreciation for the amount of time and effort that the chairmen and members of these committees give to us, the members of the Canadian Nurses' Association. We in national office are aware of the generosity of these nurses who take time out from very busy positions and heavy responsibilities to work for the advancement of our profession.

We, the CNA, would like to express to these nurses a sincere "thank you."

## *Le Nursing à travers le pays*

### *L'A.I.C. devant la Commission Gordon*

Au nombre des mémoires présentés à la Commission Royale sur l'Avenir Économique du Canada, à la séance publique tenue à Ottawa en mars dernier, il s'en trouvait un de L'Association des Infirmières Canadiennes. Ce mémoire rédigé sur le nursing, embrasse une période de 50 ans, commençant par le nursing tel qu'il était il y a vingt-cinq ans, le nursing aujourd'hui et ce que l'on en attendra dans vingt-cinq ans d'ici; on y relate des études déjà faites à ce sujet notamment le Rapport Weir, l'expérience de l'Ecole Métropolitaine de Windsor, Ont., et celle plus récente de l'Atkinson School of Nursing du Toronto Western Hospital.

Notre délégation se composait de la présidente, Mlle Gladys J. Sharpe, de la secrétaire générale, Mlle Pearl Stiver et de Mlle D. Percy, consultante en chef au Ministère de la Santé Nationale et du Bien-Être qui avait été priée de prêter son concours à la préparation du mémoire.

Dans la présentation du mémoire, on signala l'augmentation considérable du nombre d'infirmières employées dans les hôpitaux. Depuis vingt-cinq ans, le nombre d'infirmières enregistrées a triplé au Canada et il y en

a dix fois plus d'employées dans les hôpitaux. Cette augmentation indique que les soins donnés aux malades sont de meilleure qualité. Aujourd'hui, dans les hôpitaux, les soins sont donnés en grande partie par des infirmières professionnelles tandis qu'autrefois ils étaient presque entièrement confiés à des étudiantes.

Lorsqu'on considère l'augmentation de la population du Canada, les nombreux programmes de santé qui s'imposent et, par conséquent, une demande correspondante d'infirmières, on ne peut s'empêcher de se poser les questions suivantes:

1. Où pourra-t-on trouver un nombre suffisant d'infirmières?

2. Comment peut-on être certain qu'elles seront préparées à donner les meilleurs services possibles à la population canadienne de même qu'à l'étranger, dans la réalisation des programmes internationaux de santé.

L'on s'inquiète aussi du petit nombre d'étudiantes qui se rendent au terme du cours primaire supérieur. Encourager les étudiantes à poursuivre leurs études supérieures et leur assurer un appui financier à cette fin, serait un excellent moyen d'augmenter les rangs parmi lesquels on pourrait choisir des candidates pour le cours d'infirmière ainsi que pour d'autres professions.

NOW . . . you'll always be a woman in WHITE!

New dip-'n'-dry

## TERYLENE\* UNIFORMS

- ... are not yellowed  
by detergents
- ... resist wrinkles better than  
anything you've ever  
worn before

'Terylene', the talented new textile fibre brings you smart, new uniforms that are about as "work-free" as any garments could be. They wash in a wink, drip-dry in a couple of hours and need practically no ironing. No wrinkles while you wear 'Terylene', and no wrinkles after washing 'Terylene'. Remember, it *stays white*, too!

White Sister Uniforms of 100% 'Terylene' are now available in stores across the country.

*keep your eye on*



\*Registered trade-mark polyester fibre



Il est relativement facile de prédire les besoins futurs du Canada pour répondre à l'accroissement des services de santé, si l'on examine la proportion du nombre d'infirmières par rapport à la population depuis vingt-cinq ans.

En 1931, il y avait au Canada une infirmière pour 576 personnes et du chômage parmi les infirmières.

Aujourd'hui, il y a une infirmière pour 286 habitants et l'on manque d'infirmières.

Les besoins majeurs en nursing au point de vue de l'économie future du Canada furent énumérés comme suit :

La nécessité de déterminer, au moyen de recherches :

Les besoins de la population en matière de nursing pour l'exécution du programme de santé actuel et futur.

Le personnel requis.

Les moyens les meilleurs et les plus économiques de préparation du personnel requis.

Les avantages de nos programmes actuels et la nécessité d'en faire une évaluation en regard du développement et des progrès de la science médicale.

Le besoin d'aide financière :

Pour s'assurer les services de personnes capables d'exécuter telles recherches et de les préparer en conséquence, puis pour défrayer le coût de la recherche proprement dite.

Pour assurer un programme véritablement éducatif en nursing ; les candidates qualifiées ne devraient pas être empêchées de s'inscrire à l'école d'infirmières par le manque de ressources financières. Elles devraient pouvoir bénéficier de bourses d'études pour leur permettre de faire le cours d'infirmière.

Pour permettre aux infirmières qualifiées qui pourraient occuper des postes de commandement de se préparer en conséquence.

### *Parlons d'accréditation*

Lors du 28ième Congrès National à Winnipeg, si vous désirez participer à la discussion pendant la journée consacrée à l'éducation, il serait bon de vous y préparer par un peu d'étude. L'A.I.C. et le Comité de l'Education en nursing vont vous demander de penser sérieusement à notre responsabilité concernant de nouvelles méthodes d'évaluation de nos écoles d'infirmières du Canada. Un programme d'accréditation serait peut-être la solution à ce problème. Une série d'articles sur ce sujet a paru dans l'*Infirmière Canadienne* en 1950. Les informations qui s'y trouvent devraient être connues de toutes celles qui seront appelées à exprimer

une opinion. Alors, rafraîchissez votre mémoire sur les principes de l'évaluation et de l'accréditation en consultant les numéros suivants de *L'Infirmière Canadienne* : février, page 112 ; mars, page 187 ; avril, page 278 ; juin, page 460 ; octobre, page 819.

### *Infirmières canadiennes au Ceylan*

Nous nous rendons compte que les infirmières employées par les agences internationales de santé ne nous oublient pas. Le secrétariat national reçoit souvent des demandes de renseignements, d'imprimés, etc. de la part d'infirmières au service de l'Organisation Mondiale de Santé et du Plan Colombo, et de tout ce qui peut les aider à développer leur programme d'enseignement dans ces pays moins privilégiés. Nous avons trouvé au cours de nos recherches un catalogue publié par "The Chicago Medical Book Company", Jackson and Honore Streets, Chicago 12, Illinois, contenant une liste de manuels en nursing, indiquant la date de publication et le nom de l'éditeur.

### *Questions et réponses*

Ici, au secrétariat général, des questions nous sont fréquemment posées auxquelles nous ne pouvons répondre à moins que chacune d'entre-vous nous accorde sa collaboration. Les informations sur les statistiques nous viennent de différentes sources : archives de l'A.I.C., recensement de 1951, statistiques vitales 1953, statistiques concernant les hôpitaux, sanatoria de tuberculeux, d'hôpitaux pour maladies mentales, 1954, etc. Nous nous rendons compte que ces renseignements ne sont pas toujours exacts ni complets. Nous sommes actuellement à préparer un questionnaire concernant les besoins en nursing au Canada dont nous tentons de faire un estimé. Ce questionnaire sera prêt en septembre prochain et distribué par l'entremise des secrétaires-registres des associations provinciales. Le succès de cette entreprise dépendra en grande partie de la coopération de chaque infirmière canadienne. La réponse à ce questionnaire nous donnera des renseignements exacts et complets que notre bureau national pourra à son tour transmettre. Cette information est essentielle si nous voulons être capables de faire connaître nos besoins aux membres de notre profession et au public, lesquels pourront ensuite nous aider à trouver les voies et moyens par lesquels nous pourrions satisfaire aux exigences croissantes des services que l'on attend de nous, infirmières.



# BABY'S OWN SOAP

*a favorite for over eighty years!*



Baby's Own Soap is a pure soap, super fatted with a special extract of lanolin, to make it mild and gentle for the tender skin of babies. It contains no free caustic soda, no coloring agents or fillers. Thorough tests show that components of the perfume which gives Baby's Own its fresh and delicate aroma are entirely free of elements which would affect the normal skin of babies. Its rich lather gets baby's skin thoroughly clean and clears tiny pores of impurities.

For over 80 years, Baby's Own Soap has been the favorite of Canadian mothers. It has won this long standing faith because it is a product of rigid laboratory control. Automatic processing and close inspection assure uniformity of its high standard of quality. Finally each cake of Baby's Own soap is individually wrapped and boxed to ensure protection of its purity right to the time of baby's bath.

## Baby's Own 3 step-care



## Une expérience professionnelle

A l'instant où nous écrivons ces lignes, nous recevons une affiche soulignant les points importants du 28ième Congrès biennal. Vous l'avez peut-être déjà vue au tableau d'affiche de votre hôpital ou de votre service de santé ou nous espérons que vous l'y verrez prochainement.

L'on nous annonce aussi que la conférence donnée en mémoire de Mary Agnes Snively, fondatrice de l'A.I.C., sera donnée par B. Hope Sanders, C.B.E., co-propriétaire et directeur du "Canadian Institute of Public Opinion"; excellent orateur et de personnalité intéressante nous sommes persuadées que vous aurez du plaisir à l'entendre.

Aurons-nous le plaisir de vous voir à Winnipeg? Si vous n'êtes pas déjà inscrite, hâtez-vous de le faire en employant la formule que vous trouverez dans ce numéro de la revue.

### Visiteurs au Secrétariat National

Il nous a fait plaisir d'accueillir, en février, Mlle E. Kathleen Russell à Ottawa; elle fait présentement une enquête sur l'éducation en nursing dans la province du Nouveau-

Brunswick. Mlle Russell nous a apporté, comme toujours, son enthousiasme et sa clairvoyance dans la discussion des choses du nursing. Bientôt nous aurons la visite de Mlle Mavis L. Avery, secrétaire-générale, de la Royal Australian Nursing Federation. Mlle Avery est en tournée d'étude au Canada à titre de boursière de l'O.M.S.; elle est actuellement à Vancouver d'où elle s'acheminera vers Ottawa et Montréal pour se rendre ensuite en Grande-Bretagne où elle continuera son étude.

### Un mot de remerciements

Le Comité national qui est à terminer les préparatifs du congrès biennal désire exprimer sa reconnaissance aux convocatrices des divers comités pour l'aide précieuse qu'elles apportent aux membres de L'Association des Infirmières Canadiennes; nous apprécions à sa juste valeur la générosité de ces personnes qui, en plus des fonctions importantes qu'elles ont à exécuter dans les postes qu'elles occupent trouvent encore le temps de collaborer à notre travail d'organisation et, par le fait même, à l'avancement de la cause des infirmières.

Nous les remercions de tout coeur.

## The Skin—Mirror of Emotions

The skin may reveal emotional states as eloquently as do the muscles of facial expression. Control of facial muscles may keep the visage inscrutable despite inner turmoil, but voluntary control is useless in suppressing the blush of embarrassment or the cold sweat of fear . . . We speak of the face that becomes "purple with rage" or "white with fear." The person impervious to insult is referred to as "thick-skinned"; the sensitive one is "thin-skinned." Aware of danger, one's "hair stands on end," he may "bristle with courage," or, frozen with fright, have *cutis anserina* (goose flesh). We refer to "sweating-out" an unpleasant

time . . . Sensory disturbances of the skin are also induced by emotions. Thus, one "tingles" with expectation or is "tickled" by an amusing incident. Hostility may cause us to "itch for revenge". A repulsive sight makes our skin "crawl" or gives us the "creeps," the very sensations of patients afflicted with delusions of parasitosis. Fearful of a venture, we speak of getting "cold feet." We are "sitting on pins and needles" while awaiting an important decision — a preface to anal and genital pruritus. The symbolism expressed by excoriations has its parallel in the remark "stop picking on me."

— GERALD M. FRUMESS

Research studies indicate that an individual's immunity to an infectious disease may be specifically altered in the presence of another disease, such as Hodgkin's. Curiously enough this inability to fight infection does not involve all types of immune response. Thus, a patient with Hodgkin's disease can resist a streptococcal throat

infection very successfully but is unable to protect himself against tuberculosis or brucellosis. This defect in the body's natural defenses lies either in an inability to produce antibodies or in its ability to transport the particular antibodies to the site of infection.

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**Nylon!**

Easy on your pocketbook, too. No laundry problems! No laundry bills! You wash your nylon uniform as easily as your nylon lingerie. It quickly drips dry for duty again with no starching needed and only the slightest touch of an iron. Easy, isn't it? You not only look smart, you *are* smart—because nylon's famous long-wearing qualities mean fewer uniforms to buy. So keep your costs down and your appearance up in attractive carefree nylon uniforms.

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*Textile Fibres Division*

**DU PONT COMPANY OF CANADA  
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# TICKET OF NOMINATIONS

## CANADIAN NURSES' ASSOCIATION

**28th BIENNIAL MEETING, JUNE 25-29th, WINNIPEG, MANITOBA**

<b>President:</b> .....	Miss Trenna Hunter .....	Director of Public Health Nursing, Metropolitan Health Committee, Vancouver, B.C. (Presently—First Vice-President)
(acclamation)		
<b>First Vice-President:</b> .....	Miss Alice Girard .....	Director of Nursing, St. Luke's Hospital, Montreal, Que. (Presently—Second Vice-Pres.)
(acclamation)		
<b>Second Vice-President:</b> .....	Miss Helen Carpenter .....	Assistant Professor, University of Toronto School of Nursing, (Presently Chairman, Committee on Legislation and By-Laws)
	Miss Muriel Hunter .....	Director, Dept. Health & Social Service, Public Health Nursing Service, Fredericton, N.B. (Presently—Third Vice-President)
	Miss Hester Lusted .....	Assistant Professor of Nursing, University of Saskatchewan, Saskatoon, Sask.
<b>Third Vice-President:</b> .....	Miss E. A. Electa MacLennan .....	Director of Nursing, Dalhousie University, Halifax, N.S.
	Miss Grace Motta .....	Superintendent of Nurses, Moose Jaw General Hospital, Sask.
	Miss Helen Wilson .....	Matron, Deer Lodge Hospital, Winnipeg, Man.
	Miss Mary E. Wilson .....	Assistant to Public Health Director, Department of Health, Winnipeg. (Presently—President Manitoba Association of Registered Nurses)
<b>Nursing Sisterhoods</b>		
<b>Maritime Region:</b> .....	Sister Helen Marie .....	Director of Nursing St. Joseph's Hospital, Saint John, N.B. (Presently—Maritime Sisterhood Representative)
	Sister Jean Eudes .....	Director of Nurses, Hamilton Memorial Hospital, North Sydney, N.S.
	Sister Mary Irene .....	Educational Director, School of Nursing, Charlottetown Hospital (Presently—President, Association of Nurses of P.E.I.)
	Sister Marie Simone .....	Director of Nurses, St. Martha's Hospital, Antigonish, N.S.
<b>Quebec Region:</b> .....	Sister Florence Keegan .....	Professor, College Marguerite d'Youville, Montreal, Que.

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*Formula:* Each Instantine-Plus Tablet Contains

Acetylsalicylic Acid,  $4\frac{3}{4}$  grains. Phenacetin,  $1\frac{3}{4}$  grains.  
Caffeine Alkaloid,  $\frac{1}{4}$  grain. Codeine Phosphate,  $\frac{1}{8}$  grain.

*Availability:* Tins of 12, bottles of 48 and 120.

THE BAYER COMPANY, LIMITED, WINDSOR, ONTARIO



Sister Mary Felicitas	Director of Nursing, St. Mary's Hospital, Montreal, Que.
Sister St-Ferdinand	Director of Nurses, St. Michael the Archangel Hospital, Quebec City, Que.
<b>Ontario Region:</b>	Sister Francoise de Chantal .....Superintendent of Nurses, St. Joseph's Hospital, Sudbury, Ont.
Sister Madeleine de Jesus	Director of Nursing Education, Ottawa University.
Sister Mary Frances de Sales	St. Michael's Hospital, Toronto (Presently—Ontario Sisterhood Representative)
Sister Mary Ursula	Director of Nursing, St. Joseph's Hospital, Hamilton.
<b>Western Region:</b>	Sister Adele Levasseur .....Educational Director, Regina Grey Nun's Hospital, Regina, Sask.
Sister Mary Beatrice	Director, St. Michael's General Hospital, Lethbridge, Alta.
Sister Mary Laurentia	Providence Hospital, Moose Jaw, Sask.

*Signed:* Dorothy Gill, *Chairman, Nominating Committee*

*Signed:* Pearl Stiver, *Secretary, Nominating Committee*

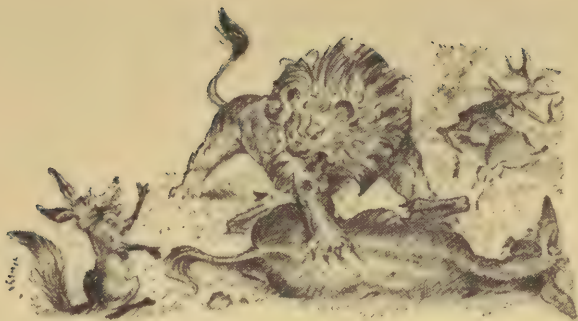
It is recommended that a program of research into the cause and prevention of heart disease should be undertaken on international lines. The disease designated for special investigation is *ischemic heart disease*. This condition is defined as "the cardiac disability, acute and chronic, arising from reduction or arrest of blood supply to the myocardium... The main pathological processes involved are atherosclerosis and thrombosis of these vessels." Angina pectoris is the most clearly recognized type of ischemic heart disease.

Factors contributing to or causing this disease are not clearly defined. A number of factors may be at work simultaneously — their action differs according to the individual and his social or ethnic group. Very striking differences are noted from country to country but the interpretation of their significance is difficult. In the USA, UK and Sweden more men than women die from ischemic heart disease, but in the Netherlands female mortality is higher. Diet and obesity may be important factors but there are populations containing many obese individuals which have a lower rate of ischemic

heart disease than the US or UK e.g. Norway or Japan. It has been noted that in areas of low-fat diet individuals have a relatively low incidence of ischemic heart disease. In Europe, under wartime conditions, reduction of fat consumption was paralleled by a lowered mortality from heart disease.

Occupational and social status may have a bearing. Professional and business men suffer from ischemic heart disease more frequently and more severely than people in more physically active jobs. The relationship between heavy smoking and cardiovascular disease is becoming more obvious. High alcoholic consumption is also connected with an excessive death rate.

The research necessary to establish a meaningful association between these factors and heart disease is felt to be one of the most difficult tasks in medical research. It has been recommended that pilot studies should be under the direction of the World Health Organization. In the meantime the best advice to be followed in the prevention of heart disease is "Be moderate in all things."— PAN AMERICAN SANITARY BUREAU



## A Lion, Ass and Fox

**A Lion**, an Ass and a Fox  
ran down a Stag and the  
Ass was to divide the Prey.  
As he was doing this  
Honestly and Innocently,  
into three equal Parts, the

Lion fell on and kill'd him.  
Then the Lion bad the Fox  
divide: who had the wit to  
put the Whole to the Lion's  
Share, Saving only a Miser-  
able Pittance for him self.

**The Moral:** "*The Folly of one Man makes another Man wise*".

Doubly wise then is he who profits by the wisdom of others  
in recognizing established quality.

### For Low Fat Diets

Borden's Starlac is an easily digested, highly palatable  
skim milk powder of prescription quality. Starlac is the  
most economical source of protein available, and is  
superior to ordinary skim milk in

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	Dry	Reconstituted*
Protein	36.5%	3.5%
Lactose	52.0%	5.0%
Milk Fat	1.0%	0.1%
Minerals	8.0%	0.8%
Calcium	1.3%	0.13%
Phosphorus	1.0%	0.1%
Moisture	2.5%	90.6%
Calories (per oz.)	103	11

\*(4 oz. by weight to 40 oz. water—1 qt.)

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Protein Milk Powder (C.M.P. Brand)

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Formula Foods Dep't., Spadina Crescent, Toronto, Ontario.

# Dish-Washing Center

GLADYS BARKER

**T**HE OLD COAL-BURNING boiler room at Grace Hospital in Windsor, Ont., has seen quite a transformation recently. It is now a dish-washing centre, with medical and surgical shipping and storage above, oxygen storage in the former coal depot, a linen storage room from the laundry, and a substation.

The dishes are scraped and put into the dish-washing machine. This is one of Hobart's latest models, and will wash and dry silver, glassware and china. A special Economy Laboratory, attached to the machine, dispenses sufficient disinfectant, and a thermostatic control keeps the temperature at a sufficiently high degree.



(Wild Studios — Windsor)

*Part of the converted boiler room*

To remove the gigantic boilers was, in itself, quite a task. Following this, the entire room was tiled — floors, walls and passageway — in red tile. A ramp replaces former steps and a further passageway leading to the elevator was also excavated and tiled.

Spotless, stainless steel shelves line the room, for dishes.

Nine women are employed full-time, and five part-time to take care of 225 trays. Following the serving of the patients' trays on the separate floors — this being a bungalow type of building — the trays are collected, put on tray racks and returned to the dish-washing centre.

Two stainless steel counters receive the trays, with garbage collectors un-

This procedure, three times a day, takes about two hours on each occasion. The trays are re-set, ready for the next meal, and taken on the tray rack to each separate floor.

Sr. Major Barker is superintendent of Grace Hospital, Windsor, Ont.

## *Did You Know —*

That the Health League of Canada reports a survey which revealed that 30 to 40 per cent of the people use little or no milk.

That 35 per cent of the milk sold in Canada for human consumption is not pasteurized.

That Ontario and Saskatchewan are the only provinces where the pasteurization of milk is compulsory.

*CAC Bulletin*



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## ***Gerber Strained Bananas***

Only fully ripe fruit used—degree of ripeness always uniform. Provides easy-to-digest carbohydrates—one of 11 Gerber Fruits for Babies.

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business... our  
only business!*



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**BABY FOODS**

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## Une Salle pour Enfants Brûlés, dans un Hôpital.

CERTAINS HÔPITAUX, notamment le Guy's Hospital, ont organisé une section spéciale pour le traitement des enfants victimes de brûlures. Celle-ci consiste en quelques chambres contiguës, à proximité du quartier chirurgical.

Une première pièce est réservée au traitement du brûlé à l'admission; sédation des douleurs, par la morphine notamment; traitement du choc par remplacement du plasma exsudé dans les tissus à l'aide de solutions salines, de plasma ou de Dextraven (très efficace et exempt de l'inconvénient que présente le plasma qui peut être vecteur de virus d'hépatite); traitement local des brûlures s'il est nécessaire (nettoyage, désinfection, évacuation des phlyctènes, mais sans enlever la peau morte à moins qu'elle ne soit visiblement infectée). Cette pièce contient donc les médicaments d'urgence, tout ce qu'il faut pour la resuscitation du malade choqué, notamment l'oxygène, le matériel nécessaire aux perfusions intraveineuses, au sondage vésical, à l'anesthésie, à la toilette et au pansement des plaies, et entre autres un stérilisateur. Le malade est traité dans la pièce d'admission durant les premières 24 ou 48 heures.

L'exposition des brûlures à l'air sans pansement ni applications locales d'aucune sorte constitue la méthode de choix chez l'enfant. Elle évite les changements douloureux de pansements qui souvent exigent l'anesthésie générale et interfèrent avec l'alimentation. En deux ou trois jours l'exsudat de la brûlure forme une croûte qui la protège de l'air et sous laquelle s'opère la cicatrisation.

Lorsque le traitement initial est terminé, l'enfant passe dans la petite salle adjacente, de trois ou quatre lits, où il séjournera jusqu'à sa guérison. Une deuxième chambre de quelques lits peut recevoir en effet soit des enfants brûlés, s'ils sont particulièrement nombreux, soit d'autres malades chirurgicaux. Les lits sont équipés de matelas en plusieurs segments, permettant d'enlever le segment sous-jacent à une brûlure. L'organe brûlé fait pont, et les contacts douloureux sont ainsi limités au minimum. Bras et jambes doivent être parfois immobilisés par des attelles pour empêcher les mouvements et frottements excessifs. L'on évite par des

linges stériles tout contact des brûlures avec la literie.

L'infection est minimisée par les précautions prises lors des soins: port du masque par les infirmières, lavage soigné des mains avant de s'approcher du patient; les antibiotiques sont utilisés préventivement, notamment la péniciline per os.

Si la brûlure n'est pas trop profonde, l'eschare se détache entre le 10<sup>e</sup> et le 20<sup>e</sup> jour. S'il faut plus de 20 jours au décollement, des greffes sont généralement nécessaires. Après 15 jours, la séparation de l'eschare peut être accélérée en imbibant de paraffine les pansements posés, ou par des applications d'enzymes. Lorsque, au bout de 20 jours, l'eschare s'est détachée, si des fragments restent adhérents ils doivent être excisés et l'on applique des greffes cutanées.

En cas de brûlure profonde bien circonscrite, l'excision initiale du tissu brûlé et la suture en tissu sain permettent une guérison très rapide. Cette méthode convient particulièrement pour les brûlures localisées profondes de la main.

Dès que le patient manifeste de l'appétit, il recevra un régime riche en calories et en protéines.

Les visites quotidiennes des parents doivent être encouragées, et au début, la présence de la mère pendant la plus grande partie du temps est désirable. Elle aide l'enfant à avoir confiance et atténue l'anxiété engendrée par l'accident.

Après les premiers jours, l'ennui devient le pire ennemi de l'enfant et il est utile de l'occuper (occupational therapy). Une activité scolaire organisée au sein de l'hôpital offre la solution la plus heureuse et détourne la pensée de l'enfant de l'accident. S'il est inoccupé, il a tendance à gratter et à arracher les croûtes, favorisant ainsi l'infection.

Ces enfants, souvent insubordonnés, doivent faire l'objet d'une surveillance attentive; il est utile d'avoir une infirmière à temps complet dans la section des brûlés: elle arrive ainsi à connaître très bien ses enfants, tandis que ceux-ci s'attachent à elle.

Elle devient experte aussi à ajuster les dispositifs qui préviennent le frottement au niveau des brûlures. La continuité de sa présence contribue à assurer une atmosphère

heureuse, si importante à la guérison.

Les parents sont très affectés durant les premiers jours; ils s'inquiètent de savoir si l'enfant gardera des cicatrices, devra être opéré, et du temps qu'il devra rester à l'hôpital. Ils éprouvent aussi un sentiment de culpabilité. La vue des brûlures non couvertes leur est particulièrement pénible. Cependant, dès que la croûte se forme, ils reprennent courage. On les aide en leur expliquant, à l'admission, le traitement que subira l'enfant et les différentes phases de la guérison. D'autre part ils trouvent un encouragement dans le contact avec d'autres parents qui peuvent leur raconter les progrès survenus chez leurs enfants, hospitalisés depuis plus longtemps.

par J. R. Tanner, *Nursing Times*  
51:220 4 mars 1955.

## The Pickwickian Syndrome

Members of the New England Cardiovascular Society heard a strange case history reported at a meeting recently. A patient was described who sought medical aid after he fell asleep in a poker game of high stakes while holding three kings and two aces. The patient was an extremely fat 54-year-old business executive. His ankles were swollen, his breathing was rapid and shallow, his muscles twitched while awake and asleep. He had a tendency to swoon and to sleep with confusion between dreaming and reality. The diagnosis was Pickwickian Syndrome.

The syndrome was first recorded in literature by Charles Dickens in *Pickwick Papers*. Dicken's "wonderfully fat boy," Joe, is a vivid description of this pathologic state characterized by obesity, sleepiness, excessive appetite and fatigue. The syndrome is explained by a tremendous increase in abdominal girth with decrease in pulmonary reserve and pulmonary ventilation. To establish the diagnosis there must be no significant disease condition other than obesity and the syndrome must be reversible with weight reduction. On a diet the patient's weight fell from 263 pounds to 226 lbs. and sleepiness, swollen ankles and shallow rapid respiration disappeared.

— COMMUNICATIONS ASSOCIATES

\* \* \*

There would be fewer accidents on the highways if all the fast drivers were also fast thinkers.



## "A new beauty tablet?"

Not exactly . . . but since pain and beauty never go together, we thought you would like to know about Veganin tablets.

Veganin helps to bring swift welcome relief at specially difficult times, or at any time pain strikes . . . helps to calm jittery nerves without producing a feeling of drowsiness or upsetting the stomach.

For "stronger" relief, it's Veganin with approximately 8 grains of anti-pain medication. Recommended by physicians and dentists. Available in handy tubes of 10's and 20's.



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# Book Reviews

**Program Guide for Future Nurses' Clubs,** 78 pages. Published by the National League for Nursing Education, 2 Park Avenue, New York 16, N.Y. 1955. Price 50 cents.

*Reviewed by Mrs. Fay Cohen, Jewish General Hospital, Montreal.*

This book is well constructed and entertainingly written. It is easy to follow; answers all possible questions about organization of the clubs and suggests projects that allow for active participation of all club members. The Program Guide should be kept in grammar school and high school libraries, and on the desk of every vocational guidance counsellor. Its pages contain much general information on nursing, both professional and practical.

However, it should be pointed out that some of the projects mentioned in the "Guide" are essentially for use in clubs in the United States. Therefore, clubs and projects here should be considered after consultation with an adviser active in nursing and the community. The book is practically a "Who's Who" of the various fields of nursing open to those making nursing their career.

The advice given; the projects suggested; and the careful appeal given to make youth aware of its place in the community makes this an invaluable aid in student nurse recruitment.

**Manuel du Service du Nursing à l'Hôpital,** 117 pages. Ce volume est une traduction, par le Ministère de la Santé Nationale et du Bien-Etre, de l'ouvrage intitulé: "Nursing Service Manual" publié par la National League of Nursing Education. On peut se le procurer au bureau de l'Association des Infirmières de la Province de Québec, 506 Edifice Medical, Arts, 1538 avenue, rue Sherbrooke, Montréal 25, Qué. *Revue de ce manuel par Soeur Florence Keegan, M.Sc., institutrice à l'Institut Marguerite d'Youville, Montréal.*

Le service des malades dans l'organisation complexe de l'hôpital moderne a créé, depuis quelques années, le besoin d'un manuel d'organisation et d'administration pour le département du nursing. Le désir des directrices du nursing et des infirmières de nos hôpitaux canadien-français, vient d'être comblé puisque le Manuel du service du nursing à l'hôpital,

publié sous l'égide de l'American Hospital Association, de la National League of Nursing Education en 1950 a été récemment traduit en français.

Ce travail met en lumière les principes fondamentaux d'un bon service du nursing à l'hôpital et a pour but de servir de guide aux administrateurs, aux directrices du nursing et au personnel infirmier des hôpitaux d'expression française. Ce volume, de format plutôt restreint, présente une somme de matière considérable sous une forme synthétique et condensée. Celles qui ont la responsabilité du soin des malades trouveront le manuel indispensable. En plus de traiter particulièrement de l'organisation du service du nursing à l'hôpital, il offre de nombreuses suggestions très utiles et faciles à adapter pour évaluer ce même service dans n'importe quelle situation.

Le premier chapitre étudie le rôle que joue le service du soin des malades dans l'organisation et la structure administrative d'un hôpital. Suivent les principes d'organisation qui sont la base d'une bonne administration, mettant en rapport méthodique tous les rouages d'une entreprise afin d'atteindre les fins désirées. Dans les cinq chapitres suivants on trouve une description des fonctions du personnel infirmier, de sa compétence et des rapports interdépartementaux, et les méthodes pouvant servir à perfectionner la coordination des services. Les trois derniers chapitres concernent le budget et la comptabilité, les registres, les rapports, etc., en un mot toutes les dispositions administratives nécessaires au bon fonctionnement du service des soins aux malades.

Les chapitres sur les "mesures administratives assurant le service des soins infirmiers" sont surtout à propos et seront particulièrement consultés avec avantage par la directrice du nursing dans l'organisation du personnel professionnel et nonprofessionnel d'un service de malade. Ils indiquent les éléments importants qui influencent et modifient les mesures administratives; ils contiennent aussi des tableaux et des illustrations pratiques sur les méthodes à employer pour déterminer le nombre et la composition du personnel infirmier d'un service de malade à l'hôpital. Chaque chapitre s'enrichit d'une excellente bibliographie de sources particulièrement choisies et facile d'accès; de plus, leur brièveté rend leur consultation pratique.

Ce petit livre plaira à tous ceux qui s'inté-

ressent à la science hospitalière. De format réduit et d'une lecture facile il est bien adapté à son but; cet effort de publication est évidemment un excellent moyen administratif qui devrait contribuer grandement à la solution des problèmes toujours croissants de l'administration hospitalière. On ne saurait trop recommander la diffusion de ce volume, préparé avec compétence dans le but de faciliter le service du nursing.

**Physical Therapy After Amputation, the Treatment of the Unilateral Lower Extremity Amputee**, by Margaret Bryce. 93 pages. The University of Wisconsin Press, 811 State St., Madison, Wis. 1954. Price \$1.50.

*Reviewed by Lottie Smith, Nursing Arts Instructor, General Hospital, Kingston, Ont.*

In this manual the author has achieved her purpose which is stated thus: "To provide physical therapists and students of physical therapy with an outline of basic techniques for the treatment of the unilateral lower extremity amputee."

The topics dealt with give a complete picture of the physiotherapy measures employed. These are bed positioning, bandaging, exercises, prosthetic training, limps, prosthesis and the suction socket. The material is suitably illustrated with twenty line drawings. A time table showing the progress of the patient from the time of operation to his final discharge from hospital five months later and a bibliography complete the material. The information given in this book would be very useful to all the members of the team engaged in the rehabilitation program of the amputee. The text is valuable as a hand book for the patient. The material on bed positioning, bandaging and exercises would be helpful to the nursing staff who, as the author states, "should be well aware of the importance of correct bed position and of the role of the nurse in the early treatment of the amputee."

The problems which arise in fitting a patient for an artificial limb and training him how to use it are dealt with in some detail. Unfortunately the psychological implications involved are not discussed.

**Attitudes in Psychiatric Nursing Care**, by M. Olga Weiss, B.Sc. 111 pages. G.P. Putnam's Sons, 2 West 45th St., New York City. 1954. Price \$2.00.

*Reviewed by Sister Thomas Joseph, Halifax Infirmary, Halifax, N.S.*

In this practical book a veritable banquet of thought is prepared for the reader by the

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will thank you  
for recommending*

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well-qualified and experienced author. The objectives are clearly defined and covered in a concise, succinct style. They run parallel with clarity of thought and breadth of vision.

The value of this book rests on the fact that it is neither narrow in scope nor burdened with baffling psychiatric terms. True, it is directed primarily toward the needs of the mentally ill patient, but it covers many of the intangible problems present in general nursing. This book could be used to advantage by both teacher and student, in such allied subjects as professional adjustments and mental hygiene. The dominant characteristics of the ideal psychiatric nurse are portrayed in these words: "The nurse must, in short, be prepared to see naked emotions and must be able to meet them with warmth, understanding and relaxation."

Miss Weiss' book, with its valuable reference lists at the end of each chapter, is a choice selection among the various books written on nurse-patient relationships.

\* \* \*

One's ability to overcome temptation is in direct proportion to the distance from it.

\* \* \*

Babies may develop flat feet or become pigeon-toed if they sleep too much on their abdomens during early months of life.

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## New Sounds In The Nursery

All over the world attitudes towards parent-infant relationships are changing. One event reflecting this change is the growing popularity of "rooming-in" for mothers and their infants. This has been, in the past, an isolated and — in some areas — controversial practice. Rooming-in avoids the two dangers always present when large numbers of infants are congregated in a nursery — the spread of infection and accidents. An equally important advantage is that the mother gets to know her baby and learns how to care for him. In a normal maternity case, the mother, while still in bed, can feed, bathe and care for her child with benefit both physically and psychologically to herself.

— COMMUNICATIONS ASSOCIATES, INC.

\* \* \*

Society so far has found no other means of dealing with mothers convicted of child neglect than by imposition of a prison sentence. Often this means disrupting an entire family. A new experiment is in process. Mothers, convicted of neglect, can voluntarily choose to enter a training home with all their children who are under 5 years of age. There they learn about child care and the art of making a home.

— COMMUNICATIONS ASSOCIATES, INC.

## In the Good Old Days

*(The Canadian Nurse — MAY, 1916)*

Now that the convention is so near, all the associations will be completing their arrangements for sending their delegates... The nurses of Winnipeg are enthusiastic about the convention and are very busy making ready for their guests.

\* \* \*

A most interesting lecture on suffrage was delivered giving the reasons why women should have the vote. In the first place, men have no right to withhold it; secondly, women are citizens the same as men. They have to abide by the laws men make, and while it is denied them to even place their foot on the bottom rung of the ladder of government, men forget that they allowed a woman to be at the top of the ladder — surely there

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culosis Nursing.

*For further information apply to:*

**Director of Nursing,  
Mountain Sanatorium,  
Hamilton, Ontario.**

never was a more womanly woman than  
Queen Victoria!

\* \* \*

The result of school nurses' work has  
been so successful that there is now, though  
it is only eleven years since the first school  
nurse was appointed in America, no city  
or town or any size in Canada or the United  
States without its staff of school nurses  
and many country places are employing  
nurse for a group of schools.

\* \* \*

The British Columbia Association of  
Graduate Nurses . . . decided that the  
importance of the proposed bill providing  
for the registration of practising nurses  
throughout the province, and the standard-  
ization of the training curriculum in the  
various hospitals, impelled the association to  
again press for its consideration at the pre-  
sent session of the Legislature.

\* \* \*

The annual report of the Victorian Order  
of Nurses indicated that there were 292  
members working under the Order. During  
the year 44,175 patients were cared for and  
308,548 visits were made by the district  
nurses.

In truth, the best social workers are  
mothers.

\* \* \*

A good many new and good things in  
medicine were developed in old hospital  
buildings.

\* \* \*

Hardening of the heart ages people more  
quickly than hardening of the arteries.

## Ontario

The following are staff changes in the  
Ontario Public Health Nursing Services:

**Appointments** — *Elphegina Parenteau*  
(Ottawa Gen. Hosp., U. of Montreal) to  
the Eastview Board of Health. *Mary*  
(*Boden*) *Sutherland* (Royal Inland Hosp.,  
Kamloops, U.B.C.) to East York-Leaside  
Health Unit. *Rena* (*Reynolds*) *Harris* (P.  
E.I. Hosp., Dalhousie Univ.) and *Eleanor*  
(*Mason*) *McLean* (Hamilton Gen. Hosp.  
and U. of Toronto) to Stormont, Dundas  
& Glengarry H.U. *Wilma Winkelman*  
(Tjokini Hosp., Indonesia and Netherlands  
Diploma "A" in P. H. Nursing) to Toron-  
to Dept. of P.U.

**Resignations** — *Jean Rhoten* from the  
position of supervisor, Timiskaming H.U.

# News Notes

## ALBERTA

### DISTRICT 8

#### LETHBRIDGE

Fifty members attended the chapter meeting in February and elected the following slate of officers: J. Montelth, president; Mrs. McKenzie, 1st vice-pres.; Sister Mary Peter, 2nd vice-pres.; E. Whittaker, sec.; Mrs. Montgomery, treas.

Dr. McTavish was the guest speaker at the March meeting. He chose various aspects of psychiatry as his topic.

## BRITISH COLUMBIA

### EAST KOOTENAY DISTRICT

#### CRANBROOK

Mr. J. S. Dunlop was the guest speaker at a recent chapter meeting. Mr. Dunlop was instrumental in the development of the local district unit of the Canadian Arthritis and Rheumatism Society. In his address he outlined the growth of this society on the national, provincial and district levels. Mrs. C. Ferguson reported on the councillors' meeting held earlier in Vancouver. Members expressed their regret in losing Sr. Thérèse Amable from their organization. Sister Amable is now the Superior of the Lacombe Home in Midnapore.

#### FORT GEORGE

Mrs. A. Embleton, retiring chapter president, reported an active and successful year during 1955. The slate of officers elected for the new term of office included the following: Mrs. Doreen Park, pres.; Mrs. G. Ferry, vice-pres.; E. Quenville, sec.; Mrs. I. Ford, treas. A highlight of this annual meeting was a panel discussion of the topic "Are We Caring For the Chronically Ill?" Participating in the panel were Dr. P. W. Caron, Mrs. B. Moran of the Social Welfare Department, Mrs. P. Yabolnitsky of the Cariboo Health Unit and Mrs. W. Warner of Prince George Hospital records department.

### KAMLOOPS-OKANAGAN DISTRICT

#### VERNON

The following members have been elected to the executive of the Kamloops-Okanagan district: Mrs. A. Paterson, pres.; Mrs. C. Pearson, 1st vice-pres.; M. Rowles, 2nd vice-pres.; Mrs. E. Howes, sec.-treas.

#### VANCOUVER

#### *St. Paul's Hospital*

Members of the alumnae association participated in the reception which followed a



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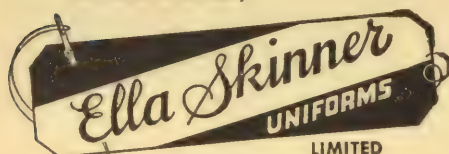
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recent capping ceremony for 66 preclinical students. Mrs. Collishaw, president of the association, was a guest speaker during the orientation program for the class of 1959. She dealt with spare time recreational activities.

Dr. F. McCaffrey and Mr. N. McMillen discussed the topic of anesthesiology in a most able manner at the regular alumnae association meeting in March. Plans for the annual spring dance under the convenership of Mrs. P. Tapping and Mrs. C. Fordyce are well advanced.

K. Dufton is nursing with the Norman Wells (Oil Industry) in the Peace River area.

## VANCOUVER ISLAND DISTRICT

### COMOX

The Plateau chapter held their annual meeting early in February with election of officers for the present year. The following members form the executive: M. Cutler, pres.; Mrs. W. K. Hind, vice-pres.; Mrs. R. Williamson, sec.; Mrs. P. Cliffe, treas. M. Cutler represented the chapter at the annual district meeting in Victoria.

Late in February approximately 16 members attended the course in body mechanics conducted by Sr. M. Eucheria, Sr. M. Carmichael, Sr. M. Margaret Ann, M. Cutler, and Mrs. W. Hind. Staff nurses from St. Joseph's Hospital have been given a similar opportunity to attend the course. For all who had completed this special training, a movie entitled "The Rehabilitation of Paraplegics" was shown following the lecture series.

### NANAIMO

At the annual meeting of the chapter held earlier this year the following members were elected to executive positions: Mrs. M. Belton, pres.; Mrs. V. Murray, vice-pres.; Mrs. L. Akenhead, sec.; Mrs. I. Walker, treas.; Committees: Publicity, Mrs. B. Bennett; Bursary, Mmes. J. Wilson, G. Dorman, Miss D. Carter; Sick Visiting, Mrs. R. Hulme; Civil Defence, Mrs. J. Wilson; Entertainment, Mmes. S. Mouatt, J. Best; *The Canadian Nurse*, E. Williamson.

## WEST KOOTENAY DISTRICT

### ROSSLAND

A resume of activities for 1955 indicated an active and successful year. A total of eight guest speakers provided programs of an interesting and educational nature. A successful home nursing series was conducted and graduation certificates were presented by Mrs. L. deSatge, provincial director for Red Cross Home Nursing. A rummage sale and dance provided sources of revenue. Two high school students, entering nursing as a career, received awards of \$25, while a donation was made to the hospital to aid in the purchase of an incubator. Among those elected to serve on the executive for

the current season were: Mrs. E. V. Topliff, pres.; H. Schreuer, vice-pres.; Mrs. P. Prestley, sec.; Mrs. R. A. Williamson, treas.

The guest speaker, Dr. R. Jones, chose as his subject "Hemolytic Disease of the Newborn," providing the opportunity for his listeners to refresh their fund of knowledge concerning the Rh factor. Members were interested to learn that F. McLean had been selected to represent Nelson chapter at the Civil Defence College, Arnprior, where a course on "Casualty Simulation for Civil Defence," was presented.

## MANITOBA

### BRANDON

The Graduate Nurses' Association enjoyed a most pleasurable deviation from professional activities by delving into the mysteries of palette and paint brush at the March meeting. Mrs. E. J. Skafel, a well-known city artist, impressed her listeners with the happiness and personal enrichment to be found in expression of one's artistic talents. She displayed several of her own paintings as well as those of a contemporary artist.

The association has contributed a sum to the Florence Nightingale church fund in recognition of its desire to preserve the church attended by Florence Nightingale. The annual open house at the Sanatorium was held late in March and the nurses' association tea took place in April.

## NEW BRUNSWICK

### SAINT JOHN

A regular chapter meeting was held in the hospital residence late in February with W. Hooser presiding. The guest speaker, Miss C. Wells, cerebral palsy speech therapist, chose language, articulation and voice in relation to cerebral palsy as her topic.

The directors of the Victorian Order of Nurses entertained the director and staff of the local VON following the annual meeting. The hostesses, Mrs. MacMurray, Mrs. J. F. Edgecombe, Mrs. H. MacKay, Mrs. G. W. Ross, Mrs. R. T. Hayes, Mrs. A. J. Coughlan, Mrs. A. B. Gilbert and Miss G. Sullivan entertained at a buffet supper.

### St. Joseph's Hospital

Twenty-one students received their caps from Sister Helen Marie following a short religious ceremony in the chapel. The capping pledge was led by Dr. Gallagher. The students entered the chapel carrying small Nightingale lamps and lighted them from a large one held by Miss Elsie Coughlan, director of nursing education.

Members of the February graduating class — N. Belliveau, E. Cunningham, S. Gillis and N. Wedge — were entertained at dinner at the Union Club by Dr. and Mrs. Joseph A. McDougall.

S. Gillis has joined the staff as assistant head nurse in the central dressing room.

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## ONTARIO

### DISTRICT 5

#### TORONTO

##### *Western Hospital*

Miss Gladys Sharpe, as guest speaker at a recent alumnae meeting, gave an account of her experiences during her visit to Istanbul, Turkey, last summer. The annual dance in honor of this year's graduating class was held in February at the Royal York Hotel. It was well attended and enjoyed by all participants.

The members elected to serve on the executive of the association during this year include: G. Saunders, pres.; J. Taylor, 1st vice-pres.; Mrs. J. M. Gibson, 2nd vice-pres.; Mrs. B. C. Prior, rec. sec.; J. Schedewitz, corr. sec.; J. Scott, treas.

##### *Women's College Hospital*

A meeting of the alumnae association was held early in March in Burton Hall. Mrs. Brown from the staff of Simpson's interior decorating department gave members new and interesting ideas for brightening their homes. Plans are well advanced for the annual spring dinner and dance in honor of the graduating class.

The Marion Hilliard Fund to be used for medical research is now well over \$8,000. For those interested in contributing, the fund is to remain open indefinitely.

A. Maxwell has joined the staff of St. Boniface General Hospital. N. McCrea is working in the research department at Hospital for Sick Children. H. Muir is on the staff of the Sudbury Hospital.

### DISTRICT 8

#### OTTAWA

##### *General Hospital*

The alumnae association elected the following slate of officers for the current year: Mrs. P. Lamoureux, pres.; D. McVeigh, 1st vice-pres.; Mrs. J. Dunn, 2nd vice-pres.; P. Conway, sec.; J. Couture, treas.

The pediatric ward is to receive a gift of \$400 and an additional \$25 was voted to be used to establish a student library on the obstetrical ward. Third-year students were guests of honor at this meeting which took the form of a Valentine party.

### DISTRICT 9

#### SAULT STE. MARIE

Sponsored by the R.N.A.O. and the local Nurses' Registry, the 8th annual refresher course for graduate nurses was held in the General Hospital on February 6, 8, 13, 15. Diabetes mellitus was the subject chosen by Dr. James Gibson, while Dr. W. E. Hutchinson and Dr. A. A. Grant discussed chest surgery and mental health respectively.

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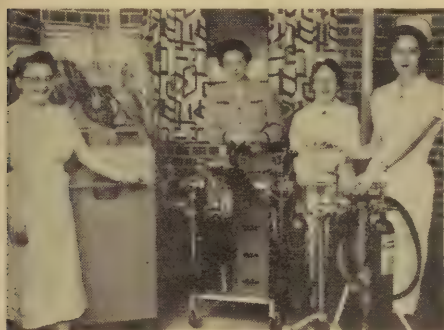
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One evening was devoted to the demonstration of hospital equipment and nursing procedures.



*Demonstrators and equipment*

On the final evening, Miss Carol Adams, educational secretary for the R.N.A.O., was the guest of honor. She explained the concept of study groups for curriculum planning and other educational projects. The course concluded with a buffet supper and social evening.

## QUEBEC

### DISTRICT 9

#### QUEBEC CITY

The nurses' residence of the new and very modern Jeffery Hale's Hospital was the gathering place for 46 members of the English chapter at their recent annual meeting. A dinner party held in the cheerfully decorated cafeteria preceded the business session. The following slate of officers was elected for the current term. J. Walters, chairman; Mrs. W. F. Greene, 1st vice-chairman; Mrs. M. Eglinton, 2nd vice-chairman; Mrs. R. Caron, sec.-treas. At the conclusion of the business session, a social hour was spent in the oak-panelled lounge of the residence.

#### *Jeffery Hale's Hospital*

Miss E. Ford and Miss E. Walsh were awarded life memberships in the alumnae association recently. At the annual meeting held late in February, the following members were elected to the executive: Mrs. J. Myers, pres.; Mrs. A. M. Seale, 1st vice-pres.; Mrs. G. Burns, 2nd vice-pres.; Mrs. K. Baptist, sec.; Mrs. E. N. Denison, treas.

### DISTRICT 11

#### MONTREAL

Pour la première fois dans l'histoire de leur communauté, des Religieuses Hospitalières de Saint-Joseph (dont la maison générale est à Montréal — Hôtel-Dieu) iront diriger un hôpital en Afrique. Six d'entre elles nous ont quittées, par avion, à destination de Porto-Novo, capitale du Dahomey français, où elles prendront la

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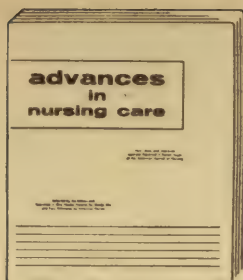
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### *Hôpital St-Luc*

Mademoiselle Michelle Thériault, a accepté un poste d'infirmière à l'Hôpital Ste-Thérèse de Chesterfield Inlet, Baie d'Hudson. Après un voyage aérien de plus de 15 heures, elle atterrit ce hameau de quelques 200 habitants, esquimaux et blancs. L'Hôpital Ste-Thérèse a 60 lits et dessert une immense région; son oeuvre merveilleuse enthousiasme Mlle Thériault.

L'Association des Infirmières de la Province de Québec, chapitre français félicite cette courageuse jeune infirmière et lui exprime ses meilleurs vœux de bonheur.

### SASKATCHEWAN

SASKATOON

*City Hospital*

Forty-three preclinical students received their caps at a recent candle-lighting ceremony attended by parents and friends. Mrs. E. Dumas, educational director, presented

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the students and Mrs. E. Hayward capped each girl. J. Peterson, who attained the highest marks in theory, received a prize and a bouquet of flowers on behalf of the Florist Telegraph Association.

Mrs. A. Colborne who has recently retired from the night supervisory staff, was the guest of honor at a tea. M. E. Talmay and Mrs. E. Hayward presented her with a gift on behalf of the teaching and administrative staff members in recognition of her service.

G. Klingenburg, N. Sanders and E. Kowalenko have joined the staff of the hospital.

### *St. Paul's Hospital*

Thirty-five students received their caps, symbol of successful completion of their preclinical term, at an impressively simple ceremony held in the chapel. Relatives and friends shared in the pride of each girl as she received her cap from Father D. Pankhurst, hospital chaplain. A brief religious service followed the presentation before students and guests assembled in the auditorium of the nurses' residence. There, pins were awarded to the members of a senior class who had reached the halfway mark in their training and 30 new students were welcomed and introduced. Each class contributed to the evening's entertainment, a special feature being the appearance of both the senior and junior Glee Clubs.

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Box 292, North Bay, Ontario;
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**Operating Room Supervisor, Night Supervisor & Staff Nurses.** Good salary & personnel policies. Living accommodations available. Apply Director of Nurses, General Hospital, Parry Sound, Ontario.

**Obstetrical Supervisor (1.) Operating Room Scrub Nurse (1.) General Duty Nurses (3)** for new 144-adult bed plus 32-bassinette hospital. Good salary & personnel policies. Apply Director of Nursing, Plummer Memorial Public Hospital, Sault Ste. Marie, Ontario.

**Supervisor (qualified.)** Good salary. Extra allowance for experience if French speaking. 5-day wk., 4-wk. vacation, 18 days sick leave cumulative annually. Car is provided. Half cost of uniform is allowed & half of Blue Cross. Workmen's Compensation. Good working conditions. Apply Sec.-Treas., Porcupine Health Unit, 164 Algonquin Blvd. E., Timmins, Ont.

**Operating Room Supervisor & Assistant Head Nurses** for children's orthopedic hospital. Good personnel policies. Pension plan available. Apply Director, Shriner's Hospital for Crippled Children, 1529 Cedar Ave., Montreal.

**Registered Nurse (1). Experienced, capable of Matronship for 8-bed hospital.** Salary: \$275 per mo. **Reg'd. Nurse (1).** Salary: \$240 per mo. Must have Sask. Registration. Holidays according to S.R.N.A. 2-wk. sick leave non-cumulative. Maintenance \$30 per mo. Apply Sec., Box 40, Union Hospital, Hodgeville, Sask.

**Psychiatric Nurse** to assume position as Head Nurse & Clinical Supervisor of new 38-bed Psychiatric Unit in a 500-bed General Hospital. An excellent opportunity for a Psychiatric Nurse who wishes to assume leadership in developing the policies, procedures & teaching program of this new Psychiatric Unit. Patients treated only by psychiatrists. The most modern facilities & treatment methods. Cooperative administration. Bachelor's Degree required plus Psychiatric experience. Salary commensurate with experience & abilities. Write Director of Nursing, Aultman Hospital, Canton, Ohio.

**Assistant Head Nurses, Surgical, Obstetrical & General Duty Nurses** for 355-bed General Hospital. Starting salary: \$260, \$270 for afternoons & nights. Apply Director of Nursing Service, St. Vincent's Hospital, 2447 N.W. Westover, Portland 10, Oregon.

**Science Instructor (1) for Aug. 1, Clinical Instructor (1.)** Good teaching facilities 1 class of approx. 30 students yearly. Good personnel policies. Near enough to Rocky Mountain National Parks for "Days Off." Apply stating qualifications & salary expected to Director of Nursing, St. Michael's Hospital, Lethbridge, Alberta.

**Science Instructor for School of Nursing.** Duties to commence August 1st. Apply Director of Nursing, Civic Hospital, Ottawa 3, Ont.

# PEDIATRIC INSTRUCTOR

Responsible for classroom and clinical instruction in pediatric nursing & co-ordinating maternal & child care program in school where organizational set-up permits stressing of patient-centred care and student-centred learning activities.

*For further information apply:*

**DIRECTOR, SCHOOL OF NURSING, METROPOLITAN GENERAL HOSPITAL, WINDSOR, ONTARIO.**

**Instructor** for school of nursing — Applications are invited for 138-bed hospital. This school is affiliated with Montreal hospitals, the teaching schools associated with McGill University. For particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

**McKellar General Hospital, Fort William, Ont. requires Clinical Instructor** in operating room. Gross salary commensurate with experience, 28 days vacation after 1 yr., 8 statutory holidays, sick leave accumulative to 60 days. Residence accommodation available at reasonable rates. Hospital has recently completed a well equipped & staffed wing with extensive renovation program progressing in the old section. Apply Director of Nursing.

**Nursing Arts Instructor for School of Nursing** — 75 student capacity. Apply stating qualifications & salary expected to Supt. of Nurses, Prince Edward Island Hospital, Charlottetown, P.E.I.

**Nursing Arts Instructor, \$400 & Reg'd. Nurses, \$310 per mo.** Retirement plan, sick leave benefits. 3 wk. vacation, 11 holidays, 40-hr. wk. New modern residence. State eligibility for California registration. Submit photograph to Director of Nurses, Tulare-Kings Counties Hospital, Springville, California.

**Nursing Arts Instructor** for School of Nursing, with capacity 195 students, attached to expanding hospital of 571 beds. B.S. Degree in Nursing Education preferred or at least 3 yrs. experience & working toward degree. Located in "All American City" of 120,000 in North Eastern Ohio with educational, industrial, recreational & agricultural primary interests. Salary commensurate with qualifications. Write Director of Nursing, Aultman Hospital, Canton, Ohio.

**Obstetrical Clinical Instructor** for School of Nursing with capacity 195 students attached to expanding hospital of 571 beds. B.S. Degree in Nursing Education preferred or at least 3 yrs. experience & working towards degree. Located in "all American City" of 120,000 in North Eastern Ohio with educational, industrial, recreational & agricultural primary interests. Salary commensurate with qualifications. Write Director of Nursing, Aultman Hospital, Canton, Ohio.

**Registered Nurses (2, experienced)** for 50-bed hospital. Salary: \$185 per mo. plus full maintenance with \$5.00 increases every 6 mo. for 2 yrs. For further information apply Matron Municipal Hospital, Wainwright, Alberta.

**Registered Nurses (2)** for new 30-bed hospital. Apply Matron, Creston Valley Hospital, Creston, British Columbia.

**Registered Nurses (3)** immediately for 36-bed General Hospital in southern Manitoba. Starting salary: \$210 per mo. with 3 wk. vacation with pay 1st. yr. employment; 4-wk. vacation thereafter. All statutory holidays. Regular sick leave, 50% Blue Cross payments. Apply Supt. of Nurses, Hospital Dist. No. 24, Box 330, Altona, Manitoba.

**Registered Nurses for new modern 20-bed hospital.** Duties to commence as soon as possible. Salary \$200 per mo. plus maintenance. \$5.00 increase every 6 mo. to maximum of \$220. Good working conditions & living quarters. Holidays after 6 mo. at rate of 2½ days for each mo. of work, maximum 30 days. Apply Memorial Hospital, Deloraine, Man.

**Registered Nurses.** Salary: \$225 per mo. gross. 5-day wk. Single room residence. 20 miles east of Toronto. Apply Supt., Ajax & Pickering General Hosp., Ajax, Ont.

**Graduate Nurses (2)** for general duty. Salary: \$250 per mo. 8-hr. day, 5-day wk. Room & board \$45 per mo. Transportation paid one way after 6-mo. service. Apply Matron, Queen Charlotte Islands Hospital, The United Church of Canada, Queen Charlotte City, B.C.



## GRENFELL LABRADOR MEDICAL MISSION

The Grenfell Mission operates four Hospitals & seven Nursing Stations in northern Newfoundland & on the Labrador. Here is a wonderful opportunity for valuable experience & an adventurous life. If you are making plans for next year, why not consider this splendid service still carried on in the name of a great man?

*For full information please write*

MISS DOROTHY A. PLANT, SECRETARY, GRENFELL LABRADOR MEDICAL MISSION  
48 SPARKS ST., OTTAWA 4, ONTARIO

**Registered Nurses.** Gross salary for nurses currently registered in Ont. \$235 per mo. Good personnel policies. New facilities. Comfortable nurses' residence. 8-hr. rotating shift. 44-hr. wk. 1 day off 1 wk., 2 the next. 1½ days holiday allowed per mo. same sick time accumulated to 90 days. 8 legal holidays per yr. The equivalent of single train fare paid up to \$40 after 1 yr. service. Apply Supt., Lady Minto Hospital, Cochrane, Ont.

**Registered General Duty Nurses** for new 58-bed hospital situated in North Western Ontario. Opening about Sept. 1, 1956. Salary: \$215 per mo. subject to increase after 6-mo. with regular annual increase thereafter. \$45 per mo. room & board. 30 days vacation & rail fare refunded after 1 yr. service. New 21-bed nurses' residence, each room having an adjoining bathroom. Apply stating age & when available to Frederick Taylor, Administrator, Dist. General Hospital, Dryden, Ont.

**Reg'd. Nurse for general duty.** Salary: \$200 per mo. plus full maintenance. Apply Little Long Lac Hospital, Geraldton, Ont.

**Registered Nurses for General Duty.** Initial salary: \$200 per mo.; with 6 or more months Psychiatric experience, \$210 per mo. Salary increase at end of 1 yr. 44-hr. wk.; 8 statutory holidays, annual vacation with pay. Living accommodation if desired. For further information apply Supt. of Nurses, Homewood Sanitarium, Guelph, Ont.

**Registered Nurses** for Psychiatry. Student affiliation or postgraduate work preferred. For information apply Director of Nursing, Victoria Hospital, London, Ont.

**Registered Nurses for floor duty for 45-bed hospital.** Good personnel policies. Apply Supt., Port Hope Hospital, Port Hope, Ont.

**Registered Nurses** for 28-bed hospital, 48 mi. southeast of Montreal. Salary \$150 per mo. \$5.00 increment every 6 mo. to maximum \$165 plus full maintenance. 1 mo. annual vacation with pay, all statutory holidays, 2 wk. sick leave, Blue Cross paid. 8-hr. day, rotating shifts. Wonderful summer resort 8 mi. from Lake St. Francis. T.V. in nurses' residence. Apply Mrs. M. G. Curran, County Hospital, Huntingdon, Que.

**Registered Nurses for Supervision & General Duty** in 150-bed Tuberculosis Hospital. 31-day annual vacation, 7 statutory holidays, 44-hr. wk. Three \$5.00 increments every 6 mo. Residence facilities available. Apply stating age, experience & salary expected to Director of Nursing, Grace Dart Hospital, 6085 Sherbrooke St. E., Montreal, Que.

**Reg'd. Nurses for modern 60-bed General Hospital** situated 40 mi. south of Montreal. Salary: \$200 per mo., additional monthly bonus for permanent evening & night shifts. 44-hr. wk., 8-hr. duty. Many attractive benefits provided. Board & accommodation available at minimum cost in completely new motel-style nurses' residence. Apply Supt., Barrie Memorial Hospital, Ormstown, Que.

**Registered General Duty Nurses** for 18-bed hospital. Salary: \$240 less \$30 perquisites with yearly increase of \$10 per mo. 44-hr. wk. Vacation with pay, all statutory holidays, liberal sick leave. For further information please telephone collect to Miss H. Moore, Matron, Union Hospital, Oxbow, Sask.

**Registered Nurses (1 or 2)** for 24-bed hospital. Salary: \$190 per mo. Full maintenance. Usual increases after 6 mo. Holidays, sick leave. Modern nurses' home. Apply Matron, Union Hospital, Vanguard, Saskatchewan.



# INSTRUCTOR

**Required before Sept. 1st, 1956**

**Prerequisite 1-year course in Nursing Education**

Allowance made for degree if experienced. Student enrollment approximately 75. 1 class per year enters in September. Teaching staff of Director of Nursing Education & 4 Instructors. New school & residence to be ready for occupancy in 1957. Guelph is a pleasant city of 38,000. 3 Colleges. Good salary & personnel policies.

*For further information apply to:*

**DIRECTOR OF NURSES, GENERAL HOSPITAL, GUELPH, ONTARIO**

**Registered Staff Nurses**, immediate appointments, in 511-bed newly enlarged and finely equipped general hospital. Duty assignments in medical, surgical, pediatrics, psychiatric, obstetrics, or contagion units. Northeastern Ohio stable "All-American City" of 120,000. In centre of area of recreational, industrial, and educational friendly activities. Living costs reasonable. Within pleasant driving-distance advantages of metropolitan Cleveland and Columbus, Ohio and Pittsburg, Pa. Friendly, cooperative work relations and conditions. Progressively advanced personnel policies. Starting salary: \$240 per mo. with 4 merit increases. Paid vacation, sick leave, recognized holidays, premium pay, sickness insurance and hospitalization program, retirement. Contact: Director of Personnel, Aultman Hospital, Canton, Ohio, by letter or collect telephone 4-5673.

**Reg'd. Nurses, Reg'd. Lab. Technicians, Physiotherapists & Anesthetists for 100-bed hospital opened in 1954.** Modern equipment, ins. plan, paid vacations & many other employee advantages are offered. Apply giving qualifications & references to Mercy Hospital, Port Huron, Michigan.

**General Duty Nurse (O.R. experience)** for 70-bed hospital on B.C. coast. Salary: \$222-\$242 per mo. less \$25 full maintenance. 28-day vacation plus 10 statutory holidays after 1 yr. Apply Matron, Saint George's Hospital, Alert Bay, B.C.

**General Duty Nurses (one, May 1 — one, June 1)** for 15-bed hospital. Starting salary: \$175 plus full maintenance with \$5.00 increases each 6 mo. for 2 years. 1 mo. vacation with pay per yr. Usual holidays. Nurses' quarters in hospital. Daily C.N.R. & bus services. Write, phone or wire The Matron, or Sec., F. J. M. Lijdsman, Municipal Hospital, Oyen, Alberta. Telephone No. 6 or 23-51.

**General Duty Nurses (3) for 31-adult bed hospital.** Salary: \$195 less \$20 perquisites. Increase of \$10 after each 6 mo. Full maintenance, separate nurses' residence. 2-wk. vacation plus 2-wk. in lieu of statutory holidays with pay after 1 yr. service. 8-hr. shifts, 48-hr. wk. Apply Matron, Municipal Hospital #19, Vulcan, Alta.

**General Duty Nurses** for 110-bed General Hospital situated in the beautiful Fraser Valley, 68 mi. from Vancouver. Good bus service. Salary: \$230 per mo. Personnel policies in accordance with R.N.A.B.C. agreement. 40-hr. wk. Residence accommodation. Apply Director of Nursing, General Hospital, Chilliwack, B.C.

**General Duty Nurses.** Salary: \$230-270, \$10 increment for experience. 40-hr. wk. 1½ days sick leave per mo. cumulative; 10 statutory holidays, (1) mo. vacation. Must be eligible for B.C. registration. Apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

**General Duty Nurses (3) for 27-bed Community Hospital by middle of June.** Salary: \$230 per mo. with annual increments of \$5.00 per mo. 40-hr. wk. 28 days vacation after 1 yr. service. All statutory holidays paid. Room, board & laundry \$40 per mo. Apply, giving full details, Matron, Slokan Community Hospital, New Denver, B.C.

**General Duty Nurses** for 430-bed hospital; 40-hr. wk. Statutory holidays. Salary: \$235-268. Credit for past experience. Annual increments; cumulative sick leave; 28 days annual vacation; B.C. registration required. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

**Royal Jubilee Hospital, Victoria, B.C.** invites applications for **General Duty Nurses** for permanent positions & vacation relief in 500-bed General Hospital. Salary \$227.50-\$262.50. 5-day, 40-hr. wk. 4-wk. vacation. 10 statutory holidays. Pension plan. Attractive employee benefits. Apply, Director of Nursing.

# GENERAL STAFF NURSES

*Required for All Departments in*

**NEW 300-BED GENERAL HOSPITAL**

**INITIAL SALARY: \$225 PER MONTH, PLUS LAUNDRY**

**EXCELLENT PERSONNEL POLICIES**

*For further information apply to*

**DIRECTOR OF NURSING, SUDBURY MEMORIAL HOSPITAL,  
REGENT STREET SOUTH, SUDBURY, ONTARIO**

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**General Duty Nurses (2) for new 42-bed hospital on sea coast, 25 mi. south of Vancouver.** Salary: \$220 for non-B.C. Registered. 40-hr. wk., 28 days annual vacation, 10 statutory holidays. Accumulated sick leave. Apply Director of Nursing, White Rock District Hospital, White Rock, B.C.

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**General Duty Nurses** for 65-bed hospital. Gross salary: \$185-\$210. 44-hr. wk., statutory holidays. For further information apply Director of Nursing Services, General & Marine Hospital, Collingwood, Ont.

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**General Duty Nurse for Surgical Unit** handling thoracic & orthopedic surgery. For further information please apply Director of Nursing, Fort William Sanatorium, Fort William, Ont.

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**General Duty Nurses** for well equipped 47-bed hospital. 8-hr. duty, 5½ day wk. Annual vacation with pay, statutory holidays. Full maintenance in new modern residence. For further information apply Supt., General Hospital, Kincardine, Ont.

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**General Duty Nurses for Medical, Surgical, Pediatrics, Obstetrics.** Good salary & personnel policies. Apply Director of Nursing, Victoria Hospital, London, Ont.

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**General Duty Nurses** for all departments. Gross salary: \$210 per mo. if registered in Ontario \$200 per mo. until registration has been established. \$20 per mo. bonus for evening or night duty; annual increment of \$10 per mo. for 3 yrs. 44-hr. wk., 8 statutory holidays, 21 days vacation & 14 days leave for illness with pay after 1 yr. of employment. Apply: Director of Nursing. General Hospital, Oshawa, Ont.

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**General Staff Nurses (immediately) for operating room.** Apply Director of Nursing, Civic Hospital, Ottawa 3, Ont.

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**General Duty Nurses (2) for well equipped small hospital for permanent staff or summer relief.** Salary: \$175 plus full maintenance. 8-hr. duty, 5½ day wk. rotating shifts, long week-end following night duty. Blue Cross. Popular summer resort. Apply Supt., Saugeen Memorial Hospital, Southampton, Ont.

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**General Duty Nurses (4) for modern active 45-bed hospital.** Busy town of 2,500. Daily bus to N. Battleford & Saskatoon. Basic salary: \$225 per mo. les \$30 per mo. for maintenance. 8-hr. rotating shift. Separate nurses' residence. Transportation by bus or rail up to an amount of \$50 allowed after 1 yr. service. Apply stating age & experience to Matron, Union Hospital, Meadow Lake, Sask.

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**General Duty Nurses (3) on or after June 15/56 for new modern 23-bed hospital of one floor construction.** Population of town 1,500. 50 mi. from the city of Prince Albert & Saskatoon with excellent train & bus connections. Gross salary: \$230 per mo. with 6 increments of \$5.00 each 6 mo. less maintenance of \$30 per mo. Apply stating qualifications & experience to J. L. Fawcett, Sec.-Man., Union Hospital, Rosthern, Sask.

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**General Duty Nurses.** All shifts, no rotation. Starting salary \$290, increases to \$349 plus shift differential of \$10. Specialty services, **Ob-Peds-Tb-Isol** \$10-\$15 extra. 5 day wk. 3-wk. vacation end of 1st yr. 11 statutory holidays each yr. Nurses' home available at \$15 per mo. Ideal location, short distance from San Francisco or mountain resort areas. Apply Director of Nurses, Stanislaus County Hosp., 830 Scenic Drive, Modesto, California.

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**General Duty Nurses** for 650-bed teaching hospital in central California. Salary: \$288-\$337 per mo. 40-hr. wk. Liberal vacation, holiday & sick leave plan. Apply Personnel Office, 510 E. Market St., Stockton, California.



## **LA SOCIÉTÉ CANADIENNE DE LA CROIX-ROUGE**

- Service général dans les avant-postes hospitaliers.
- Postes d'infirmières surveillantes et infirmières visiteuses dans les avant-postes infirmiers.
- Service de Transfusion.
- Les infirmières, possédant un diplôme reconnu par l'Association des Infirmières du Canada, devront faire parvenir leur demande d'emploi à l'adresse suivante:

DIRECTRICE NATIONALE, SERVICE DU NURSING,  
LA SOCIÉTÉ CANADIENNE DE LA CROIX-ROUGE,  
95 RUE WELLESLEY, TORONTO 5, ONTARIO, CANADA.

**General Duty & Surgical Nurses** for 64-bed acute treatment, fully accredited hospital in Northern California. Excellent living conditions. Close proximity to vacation areas for leisure time. Full details at once on salaries, working conditions, paid holidays, paid vacations, paid sick leave & other benefits. Please apply Director of Nursing Services, Clinic Hospital, Woodland, California.

**Staff Nurses** for 100-bed hospital. Gross salary commences at \$2,100. Apply Supt. of Nurses, Western Memorial Hospital, Corner Brook, Newfoundland.

**General Staff Nurses** for 400-bed Medical & Surgical Sanatorium, fully approved student affiliation & postgraduate program. Full maintenance. Recreational facilities. Vacation with pay. Sick benefits after 1 yr. Blue Cross coverage. Attractive salary; 40-hr. wk. For further particulars apply Supt. of Nurses, Nova Scotia Sanatorium, Kentville, N.S.

**Staff Nurses for 600-bed General & Tuberculosis Hospitals with School of Nursing.** Salary: \$288-\$341. Shift, special service & educational differentials, \$10. 40-hr. wk; 3-wk. vacation; 11 holidays; accumulative sick leave. Apply Associate Director of Nursing Service, County General Hospital, Fresno, California.

**General Staff Nurses** for fully accredited, private teaching hospital located on Lake Michigan, just north of Chicago. Salary range: \$303-\$328.70. Shift bonus, \$26 afternoons & \$17 nights. 5-day, 40-hr. wk. Progressive personnel policies. Excellent cafeteria & attractive rooms at reasonable rates. Please indicate type of service preferred. Apply Director of Nursing, Evanston Hospital, 2650 Ridge Ave., Evanston, Illinois.

**Staff Nurses & Operating Room Scrub Nurses** for 225-bed General Hospital on outskirts of New York City. Salary \$240-\$280; \$20 extra for O.R. duty; \$30 for permanent evening duty; \$25 for permanent night duty. Apply Director of Nursing, St. John's Riverside Hospital, Yonkers, N.Y.

**General Duty Staff Nurses**, all shifts. Salary: \$260. \$10 afternoon & night differential. 40-hr. wk. paid vacation, sick leave, 6 holidays. Write Director of Nurses, Deaconess Hospital, Spokane, Washington.

**Graduate Nurses (Labor & Delivery Rooms)** for 100-bed unit in maternity hospital. Apply Director of Nursing, Royal Alexandra Hospital, Edmonton, Alberta.

**Graduate Nurses (3)** for 24-bed hospital. Salary: \$230 per mo. if B.C. registered; less \$40 board, lodging, laundry. 1 mo. vacation after 1 yr. on full pay. 1½ days sick leave per mo. cumulative. Apply, stating experience to Matron, Terrace & District Hospital, Terrace, British Columbia.

**Graduate Nurses (General Staff Positions)** for General Hospital. Salary: \$235.50 per mo. as minimum & \$273.75 as maximum, plus shift differential for evening & night duty. 40-hr. wk. Temporary residence accommodation is available. Applicants not registered in B.C. should forward a letter of acceptance of registration in B.C. from the Registrar of Nurses, 2524 Cypress St., Vancouver, B.C. Please apply Personnel Dept., Vancouver General Hospital, Vancouver, B.C.

**Graduate Nurses & Dietician (1)** for new, very modern 88-bed hospital in a pleasant progressive town. Nurses salary: \$200 per mo. Annual increase \$10 per mo. for 3 yrs. 2-wk. shift rotation, bonus for night shifts. 1 hr. drive to Toronto & several resorts. Local swimming pool, bowling alleys, skating, theatres etc. Apply Director of Nurses, Dufferin Area Hospital, Orangeville, Ont.



# **QUEENSWAY GENERAL HOSPITAL, TORONTO 14, ONT.**

*is accepting applications for*

## **EMPLOYMENT IN ALL DEPARTMENTS**

Newest hospital in Toronto, situated on The Queen Elizabeth Way, 12 miles from downtown Toronto. Attractive residence facilities available in the new apartment type residence now under construction. Hospital scheduled to open August 1, 1956.

### **APPLY ADMINISTRATOR**

**Graduate Nurses (2) on or before May 15 for new fully modern 16-bed hospital.** Salary: \$230 per mo., \$25 deducted for full maintenance. Additional \$180 plus 1 mo. vacation after 12 mo. continuous service. New modern nurses' residence. Apply Matron, Union Hospital, Maidstone, Sask.

**Operating Room Nurses (2), Registered Nurses & Certified Nursing Assistants for general duty.** 44-hr. wk. Statutory holidays. Annual vacation with pay. For further information apply Supt. of Nurses, General Hospital, Cobourg, Ont.

**Operating Room Nurse, postgraduate training not essential.** All graduate staff. A.N.P.Q. salary scale in effect. 8-hr. day, 5½ day wk. Apply Director of Nursing, Montreal Children's Hospital, Montreal, Que.

**Operating Room Nurses,** immediate appointments, for 511-bed newly enlarged and finely equipped hospital; 10 operating rooms now completed. Northeastern Ohio stable "All-American City" of 120,000. In centre of area of recreational, industrial and educational friendly activities; living cost reasonable. Within pleasant driving-distance advantages of metropolitan Cleveland and Columbus, Ohio, and Pittsburg, Pa. Friendly and considerate working associates and conditions. Progressively advanced personnel policies. Starting salary: \$240 per mo. with 4 merit increases. Paid vacation, sick leave, recognized holidays, premium pay, sickness insurance and hospitalization program, retirement. Contact Director of Personnel, Aultman Hospital, Canton, Ohio, by letter or collect telephone 4-5673.

**Supervisor of Public Health Nursing** for generalized program in city of 43,000. 5-day wk., 1 mo. vacation with extra time at Christmas or Easter. Cumulative sick leave. Pension plan, Blue Cross & P.S.I., Workmen's Compensation. Transportation provided or allowance. For further information please write supplying details of training & experience to Dr. J. P. Wells, M.O.H., Peterborough, Ont.

**Public Health Nurse Grade 1.** British Columbia Civil Service, Dept. of Health & Welfare. Starting Salary \$255, \$260, \$266 per mo., depending on experience, rising to \$298. per mo. Promotional opportunities available. Qualifications: Candidate must be eligible for registration in British Columbia & have completed a University degree or Certificate course in Public Health Nursing. (Successful candidates may be required to serve in any part of the Province.) Cars are provided. 5-day wk. in most districts. Uniform allowance. Candidates must be British subjects; preference is given to ex-service women. Application forms obtainable from all Government Agencies, the Civil Service Commission, 544 Michigan St., Victoria, or 411 Dunsmuir St., Vancouver 3, to be completed & returned to the Chairman, Civil Service Commission, Victoria. Further information may be obtained from the Director, Public Health Nursing, Dept. of Health & Welfare, Parliament Bldgs., Victoria, B.C.

**Public Health Nurses for generalized program.** Minimum salary \$2,900 with allowance for previous experience & annual increments of \$120. Cumulative sick leave plan. Pension plan & Blue Cross plan available. Interest free loans available for purchasing cars if necessary. Liberal transportation allowance & holidays. Apply A. E. Thoms, M.D., Leeds & Grenville Health Unit, Victoria Bldg., Brockville, Ont.

**Public Health Nurses (qualified.)** Salary: \$3,100 depending on dist. served, less if in the Timmins area. Annual increment \$150 per annum for 4 yrs. Additional allowance for experience & if French-speaking. 5-day wk. 4-wk. vacation, 18 days sick leave annually (cumulative.) Car is provided. Half cost of uniform is allowed & half of Blue Cross. Workmen's Compensation. Good working conditions. Apply Sec.-Treas., Porcupine Health Unit, 164 Algonquin Blvd. E., Timmins, Ont.

## **See Quebec With Employment Rather Than A Tourist Visit**

### **OPERATING ROOM SUPERVISOR GRADUATE NURSES FOR GENERAL DUTY**

**Where?** Jeffery Hale's Hospital

**Why Unique?** Only English speaking hospital & training school in Quebec City

*For information write:*

**DIRECTOR OF NURSES, JEFFERY HALE'S HOSPITAL, 1250 ST. FOY, QUEBEC, P.Q.**

**Public Health Nurse for Town of Deep River.** Salary: \$3,005 to \$3,395 depending on qualifications. Pension, medical & vacation plans. Living accommodation in staff hotel. State all particulars including age, marital status, education & experience in first letter to "File 2A", Atomic Energy of Can. Ltd., Chalk River, Ontario.

**Public Health Nurses for Kent County Board of Health.** Minimum salary: \$2,840 with annual increases of \$150 per yr. for 4 successive yrs. 38-hr. wk., 3-wk. vacation with pay, all statutory holidays, 2-days per mo. sick leave accumulative to 48 days. Uniforms provided. Ideally located, bordered on the south by Lake Erie & by Lake St. Clair on the west. The City of Chatham being located in the centre of the County with the cities of London, Sarnia & Windsor, Ont. & the City of Detroit, Mich. all within 1-hr. drive from Chatham, makes Kent County a most desirable place in which to live & make a living. Apply W. M. Abraham, Sec.-Treas., Kent County Board of Health, 7th St., Chatham, Ontario.

**Public Health Nurses (qualified) for generalized program.** Salary \$2,700 to \$3,200 depending on experience. Annual increment \$100. 5-day wk. Pension plan. Blue Cross & P.S.I. available. Car provided or car allowance. Apply Dr. Charlotte M. Horner, Director, Northumberland-Durham Health Unit, Cobourg, Ont.

**Public Health Nurses — Generalized program.** Minimum salary: \$2,800 with allowance for experience & annual increments. Generous provision for transportation. For further details write Dr. R. M. Aldis, Director Huron County Health Unit, Goderich, Ont.

**Public Health Nurses for generalized program, bedside nursing included. Rural area.** Blue Cross & group ins. available. Good transportation policy. 4-wk. vacation after 1 yr., statutory holidays. Apply Dr. J. I. Jeffs, Lennox & Addington County Health Unit, Napanee, Ont.

**Public Health Nurses (10) —** Aug. 1 or Sept. 1 for Township of North York with over 150,000 population. Generalized program, small districts, \$60 monthly car allowance. Cumba (Medical & Hospital) Plan, group insurance, pension plan available with municipality sharing the cost of the 3 plans. 4-wk. annual vacation. Staff salary: \$3,120-\$3,640 per yr. maximum reached in 4 yrs. Address inquiries to Dr. Carl E. Hill, M.O.H., 5000 Yonge St., Willowdale, Ont.

**Public Health Nurse (qualified) for generalized program.** Salary according to previous experience with annual increases. 3-wk. annual vacation. Pension Plan. Car allowance or car provided. Apply Director Public Health Nursing, Box 404, Charlottetown, P.E.I.

**Baker Memorial Sanatorium, Calgary, Alberta,** offers to Graduate Nurses a 6-mo. post-graduate course in Tuberculosis. Maintenance & salary as for general staff nurses. Opportunity for permanent employment if desired. Spring & Fall Classes. Further information on request.

**Assistant Office Nurse for Wainwright Clinic.** Please state qualifications & salary expected. Apply Wainwright Clinic, Wainwright, Alberta.

**X-Ray & Laboratory Technician for 50-bed fully modern Municipal Hospital.** Town of 2,500. New nurses' residence. Salary commensurate with ability & experience. Apply J. A. Bloom, Sec.-Treas., Municipal Hospital, Hanna, Alta.

**Laboratory Technician** for 65-bed hospital, experienced in urinalysis, haematology, chemistry & blood bank. Living accommodation available. For further information apply Administrator, General & Marine Hospital, Collingwood, Ont.



# UNIVERSITY HOSPITAL

SASKATOON, SASKATCHEWAN

## Requires

General Staff Nurses for Medical, Surgical, Obstetrical and Pediatric Services. Forty-four hour week. Salary \$210 to \$260 gross per month. Differential for evening and night duty. Residence Accommodation if desired.

Apply to:

DIRECTOR OF NURSING, UNIVERSITY HOSPITAL,  
SASKATOON, SASKATCHEWAN

**Registered General Duty Nurses.** Salary: \$210 per mo.; after 6 mo. \$10 increase. **Operating Room Nurses,** experience not necessary. Salary: \$220 per mo. after 6 mo. \$10 increase. Benefits include free life ins., pension plan, Blue Cross, free medical & surgical care, statutory holidays, 3-wk. vacation, sick pay. Residence available. Apply Director of Nurses, Doctors Hospital, 45 Brunswick Ave., Toronto, Ont.

**Superintendent of Nurses (1).** Salary: \$275 per mo. **Graduate Nurses (2).** Salary: \$225 per mo. less \$40 per mo. room, board & laundry. 28-bed hospital, pleasant surroundings, 5 mi. from U.S. border. 40-hr. wk., 4 wk. vacation after 1 yr. service. 1½ days sick leave per mo., yearly accumulative. Nice nurses' residence. Apply The Grands Forks Community Hospital, Grand Forks, B.C.

**Night Supervisor for June, 1956.** Salary: \$2,760 to \$3,300 plus cost-of-living bonus, approx. \$325 per yr. Excellent holiday, sick leave & pension benefits. Apply, giving full particulars to The Supt. of Nurses, Baker Memorial Sanatorium, Calgary, Alta.

**Clinical Surgical Instructor for 176-bed hospital,** 40 student nurses. Salary: \$265 per mo. 1 mo. vacation per yr, 9 statutory holidays. 41½ hr. wk., off each week-end. For further information apply Director of Nursing, Providence Hospital, Moose Jaw, Sask.

**Registered Nurses.** Minimum salary: \$215 per mo. Maximum salary: \$235 per mo. Good personnel policies. Apply Supt., General Hospital, Espanola, Ont.

**Registered General Duty Nurses for 195-bed General Hospital** in pediatric, medical & surgical wards. Pharmacy. Apply Supt., Hôtel Dieu Hospital, Campbellton, N.B.

**Registered Nurses for modern, well-equipped hospital.** Salary: \$190 per mo. with a scheduled rate of increase. Previous experience recognized. 44 hr. wk., 8 statutory holidays, 1 wk. sick leave. 3-wk. vacation after 1 yr. service. Apply Supt., Memorial Hospital, Hanover, Ont.

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**Public Health Nurses (Qualified)** for generalized public health nursing service by City of Toronto, Dept. of Public Health. Salary range: \$3,186-\$3,618. Starting salary based on experience. Annual increments. 5-day wk., vacation, sick pay & pension plan benefits. Apply Personnel Dept., Room #320, City Hall, Toronto, Ont.

**Registered Nurse (July & August)** for Lake Pembina Children's Camp in Laurentians. Apply Director, 4792 Victoria Avenue, Montreal 6, or telephone ELwood 9957.



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To organize a surgical unit of 100 beds. Good personnel policies.

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## The Alice in Wonderland Syndrome

An English psychiatrist has suggested that Lewis Carroll, creator of Alice in Wonderland, who most of his life suffered from migraine headaches, went through the looking glass long before Alice did.

Carroll — like many migraine sufferers — probably experienced bizarre disturbances of the body image. These people, as Alice did in her dreams, sometimes become remarkably tall or remarkably short. Alice at times addressed herself as though she were two people, at other times she puzzled over her own identity. So do sufferers from what has been named the syndrome of Alice in Wonderland. People afflicted with this syndrome, usually epileptics or migraine suf-

ferers, experience bodily distortions comparable to the visual illusions produced by the parabolic mirrors of a fun-fair.

As an example of this syndrome, a 43-year-old housewife was referred to a psychiatric clinic with a mild anxiety neurosis complicated by disorders of the body image. She had complained of repeatedly feeling that her head was double its normal size and half its normal weight. She sometimes felt that her height had dwindled so that she was only half as tall as usual. Such case histories confirm the suspicion that Alice wandered in a Wonderland well-known to her creator.

— *Canadian Medical Assoc. Journal*

## Twelve Things to Remember

The value of time  
The success of perseverance  
The pleasure of working  
The dignity of simplicity  
The worth of character  
The power of kindness

The influence of example  
The obligation of duty  
The wisdom of economy  
The virtue of patience  
The improvement of talent  
The joy of originating.

— MARSHALL FIELD

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# THE CANADIAN NURSE

## *L'Infirmière Canadienne*

VOLUME 52

NUMBER 6

JUNE 1956

- 414** NEW PRODUCTS
- 421** OUR SENIOR CITIZENS.....*M. E. Wilson*
- 423** MANAGEMENT OF LUMBAR  
INTERVERTEBRAL DISC LESIONS.....*H. J. Rosen*
- 429** NURSING CARE OF PATIENTS WITH LUMBAR  
INTERVERTEBRAL DISC LESIONS.....*D. MacTavish and  
D. MacQuarrie*
- 431** WINNIPEG, THE FRIENDLY CITY
- 435** WE CANNOT COME DOWN.....*I. Spalding*
- 438** CONVENTION PERSONALITY
- 439** PUBLIC RELATIONS GUIDE.....*R. MacIsaac*
- 440** PROVINCIAL ASSOCIATION ACTIVITIES
- 443** ACCREDITATION —  
WHAT'S ON THE RECORD?.....*F. U. McQuarrie*
- 444** L'ACCREDITATION —  
OÙ EN SOMMES-NOUS?.....*F. U. McQuarrie*
- 445** EXPERIMENTATION DANS LE DOMAINE DE  
L'ÉDUCATION DE L'INFIRMIÈRE.....*Sr. A. Dion*
- 447** ORIENTATION.....*F. L. Campion*
- 449** RHEUMATOID ARTHRITIS.....*R. Ziehran*
- 452** IN MEMORIAM
- 454** NURSING ACROSS THE NATION
- 458** LE NURSING À TRAVERS LE PAYS
- 462** SÉLECTION
- 464** A MEMORIAL TO MARION LINDEBURGH
- 466** BOOK REVIEWS
- 472** NEWS NOTES
- 483** EMPLOYMENT OPPORTUNITIES
- 495** OFFICIAL DIRECTORY

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Jacobs & George in “Evaluation of Meat in the Infant Diet,” *Pediatrics*, 10,463 (1952) report that there was an improvement in physical growth as determined by weight and height measurement in infants first fed meat under two months of age. The same group demonstrated an improvement in hemoglobin levels; the elimination of the physiologic drop in total protein levels of the serum, with a prompt sustained rise in values, the greater part of which was composed of the globulin fraction.

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# Between Ourselves

Since Winnipeg is generally regarded as being close to the center of Canada — on an east to west basis, many of us will be travelling around two thousand miles when we set out for the CNA convention this month. That is just a routine month's driving for our guest editor, **Mary Emily Wilson**, president of the Manitoba Association of Registered Nurses. As nursing consultant in the Bureau of Public Health Nursing, Manitoba Department of Health and Public Welfare she averages nearly 25,000 miles a year in her own car as she travels her territory that stretches from the Red River and Virden Health Units in the southern section of the province to The Pas, Flin Flon and Churchill.

A graduate of St. Boniface Hospital, Miss Wilson became interested in public health nursing during the three years she served as a staff nurse in S.B.H. outpatient department. She tried visiting nursing for a year then joined the provincial health department. From 1942 to 1945, she was on loan to the Department of Indian affairs assisting in a very interesting project — vitamin research among the Indians at Norway House. During that same period the R.C.A.F. carried out an identical project with a selected group of R.C.A.F. personnel. After five years as senior nurse with the Selkirk Health Unit Miss Wilson went to Columbia University where she received her B.Sc., majoring in supervision in public health nursing.

When she is on her long jaunts about the province, Miss Wilson finds time for her creative hobbies — dressmaking, knitting, needlepoint. At home she revels in her collection of recorded music since she rarely is able to attend symphony concerts.

\* \* \*

The developments in neurosurgery have been so extensive during the past 25 years that the nurse's need to understand her role in providing effective care has become increasingly obvious. Many are receiving experience in neurosurgical nursing, either

as students or in postgraduate study. Those who do not enjoy this opportunity will welcome **Dr. H. J. Rosen's** clear description of the management of lumbar intervertebral disc lesions and the accompanying details regarding nursing care. It is interesting to note that Misses **Donalda MacTavish** and **Dorothy MacQuarrie** found a great deal more to write about the nursing care than they had first estimated there would be.

\* \* \*

Not infrequently we come across articles in other periodicals that say so expertly things that relate to our profession that we wish we could share many of those articles with you. Sometimes we succeed in finding a Canadian author to write on the topic. Sometimes we get permission to reprint the article. Very occasionally we have the good fortune to receive authorization to make the necessary adaptations so that an article from another country can be reproduced using Canadian terminology where it is applicable.

An illustration of the latter is to be found in the inspiring presentation of professional ideals by **Ione E. Spalding**. It was published originally in *Nursing Times* for October 21, 1955. You will enjoy reading this material.

\* \* \*

**Dr. Rae Chittick**, director of the School for Graduate Nurses, McGill University, has paid tribute to the lasting imprint the late **Marion Lindeburgh** has made on nursing in Canada in the description of the proposed memorial. No other form of memorial would so adequately continue the great work to which Miss Lindeburgh devoted her life.

To make the Memorial Fund a vital force in nursing education will require the donation of a large amount of money. To secure an annual interest of say \$1200 would require a principal sum of between 35 and 40 thousand dollars. It is hoped that many, many nursing organizations as well as multitudes of individual donors will quickly swell this worthy fund.

---

People are always blaming their circumstances. I don't believe in circumstances. The people who get on in this world are

the people who get up and look for the circumstances they want, and if they can't find them, make them.

— **GEORGE BERNARD SHAW**



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# New Products

Edited by DEAN F. N. HUGHES

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---

## ACTYLASEC

**Manufacturer**—Rougier Inc., Montreal.

**Description**—Each tablet contains: Acetylsalicylsalicylamide 500 mg., secobarbital sodium 16 mg.

**Indications**—Rheumatic conditions.

**Administration**—Two tablets 2 or 3 times daily

---

## BRONCHYL D

**Manufacturer**—Charles R. Will & Company Limited, London, Ont.

**Description**—Each teaspoonful contains: Dihydrocodeinone bitartrate (dicodide) 2 mg., ammonium carbonate 130 mg., ammonium chloride 100 mg., antimony and potassium tartrate 2 mg., ipecac 16 mg., menthol 2 mg., tincture of benzoin co. 0.008 ml., chloroform 0.02 ml.

**Indications**—As an expectorant and sedative for bronchial infections.

**Administration**—One or 2 teaspoonfuls as prescribed.

---

## DIACITRIN

**Manufacturer**—Charles R. Will & Company Limited, London, Ont.

**Description**—Each teaspoonful contains: Dihydrocodeinone bitartrate (dicodide) 2.7 mg., sodium citrate 160 mg., citric acid 32 mg., potassium guaiacol sulphonate 65 mg., menthol 0.5 mg., chloroform 0.008 ml., syrup wild cherry q.s.

**Indications**—An alkaline respiratory sedative for spasmodic, irritating, non-productive coughs.

**Administration**—One or 2 teaspoonfuls as prescribed.

---

## DILANCA

**Manufacturer**—Anglo-Canadian Drug Co. Ltd., Oshawa, Ont.

**Description**—Pentaerythritol tetranitrate, 10 mg. tablets.

**Indications**—For prolonged prophylaxis of angina pectoris and other states of coronary insufficiency.

**Administration**—Average dose is 10 mg. (one tablet) either before or after each meal. If incomplete relief is obtained on this dosage, it is preferable to increase frequency of administration rather than the individual dose.

---

## GELUSIL-LAC

**Manufacturer**—Warner-Chilcott Laboratories, Div. of Wm. R. Warner & Co. Ltd., Toronto, Ont.

**Description**—A water dispersible powder containing aluminum hydroxide and magnesium trisilicate combined with low-fat dry milk solids. Each heaping tablespoonful contains aluminum hydroxide dried gel 1 gm., magnesium trisilicate 2 gm., and dried low-fat milk solids 12.9 gm.

**Indications**—For peptic ulcer with major use at bedtime; for general gastric distress and simple dyspepsia; for relief of gastric hyperacidity resulting from dietary indiscretions, nervous or emotional disturbances, excessive smoking.

**Administration**—One heaping tablespoonful stirred in one-half glass of cool water (4 fl. ozs.).

---

## HONVOL

**Manufacturer**—Frank W. Horner Limited, Montreal.

**Description**—Target-activated chemotherapy for prostatic carcinoma. Each 5 cc. ampoule contains 250 mg. stilbestrol diphosphate sodium.

**Indications**—For the treatment of prostatic carcinoma.

**Administration**—For intravenous injection only.

---

## VERATRITR-R

**Manufacturer**—Irwin, Neisler & Co., Decatur, Ill., and Toronto, Ont. Quebec Distributors — Herdt & Charton, Inc., Montreal.

**Description**—Each tablet contains: Phenobarbital  $\frac{1}{8}$  gr., reserpine 0.05 mg., cryptenamine 0.3 mg. (as tannate salt), sodium nitrite 1.0 gr.

**Indications**—Treatment of hypertension in elderly people. It improves the circulation of vital organs and relieves headaches and dizziness. Rauwolfia, by its sedative action, gives the patient a sensation of well-being.

**Administration**—3 to 6 tablets daily preferably 2 hours before meals.

---

*The Journal presents pharmaceuticals for information. Nurses understand that only a physician may prescribe.*

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N.B.: The School of Nursing also offers, for high school graduates with University Entrance, a Basic Professional Course leading to the degree of B.S.N.

For further information write to the

**DIRECTOR, SCHOOL OF NURSING, UNIVERSITY OF BRITISH COLUMBIA,  
VANCOUVER 8, BRITISH COLUMBIA.**

## MYCOSTATIN OINTMENT

**Manufacturer**—E. R. Squibb and Sons of Canada, Limited, Ville St-Laurent, Montreal.

**Description**—Contains 100,000 units of mycostatin, (nystatin) per gram of plastibase.

**Indications**—For the treatment of fungous infections of the skin when *Candida albicans* (monilia) is the causative organism. Effective antibiotic therapy for dermatophytosis ("athlete's foot"), perleche (infection at the corners of the mouth, usually causing cracking of the skin), intertrigo (infection of areas of the skin where chafing is apt to occur, such as between the fingers, the thighs and at the armpits), "diaper rash", and all other mycotic infections of the skin caused by monilia.

**Administration**—To be applied directly to monilial lesions once to several times daily. Its use should be continued until the lesions have healed.

## PARENZYMOL

**Manufacturer**—Frank W. Horner Limited, Montreal.

**Description**—A sesame oil suspension of the proteolytic enzyme trypsin. Each cc. of the suspension contains 5 mg. of trypsin.

**Indications**—Produces rapid reduction of acute local inflammation in: phlebitis (thrombophlebitis, phlebothrombosis); ocular inflammation (iritis, iridocyclitis and chorioretinitis); traumatic wounds. Also effective in the treatment of leg ulcers.

**Administration**—For intramuscular use only.

## RELISSEN

**Manufacturer**—Paul Maney Laboratories Canada Ltd., Hamilton, Ont.

**Description**—Each tablet contains: Salicylamide 250 mg., mephenesin 250 mg., ascorbic acid 15 mg.

**Indications**—As an antispasmodic-analgesic for relief of pain and spasm of skeletal muscles.

## THIOSULFIL SOLUTION

**Manufacturer**—Ayerst, McKenna & Harrison Ltd., Montreal.

**Description**—Sulfamethylthiadiazole 40 mg. per cc. (4%) in a stable, non-irritating solution.

**Indications**—For ophthalmic instillation in conjunctivitis and other superficial eye infections due to susceptible organisms. For nasal instillation in infections due to susceptible organisms. In both instances, for prophylaxis before and after surgery.

**Administration**—Ophthalmic use: 3 drops instilled into the conjunctival sac 2 or more times daily. Nasal use: 5 to 10 drops into each nostril with head tilted backward, 2 or more times daily. Silver preparations should not be used concomitantly.





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## School of Nursing

1956-1957

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For additional information, write to:

**School of Nursing, Hamilton College,  
McMaster University, Hamilton, Ontario.**

#### SUSTAGEN

**Manufacturer**—Mead, Johnson & Company of Canada, Limited, Toronto and Belleville, Ontario.

**Description**—Each pound supplies: Vitamin A 2800 I.U., vitamin D 700 I.U., thiamine 5 mg., riboflavin 5 mg., ascorbic acid 150 mg., niacinamide 50 mg., pyridoxine HCl 2.5 mg., calcium d-pantothenate 20 mg., vitamin B<sub>12</sub> 5.0 mcg., folic acid 3.5 mg. Each 100 gm. supplies 385 calories; 257 gm. supplies 1000 calories; 1 ounce supplies 110 calories.

**Indications**—A therapeutic food for complete nourishment of patients who cannot or should not take food by mouth. May be used for tube-feeding. Also provides a nourishing drink when mixed by shaking or beating with water — chocolate syrup, vanilla, or other flavour may be added.

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**Indications**—Infections caused by organisms susceptible to Tetracycline when the severity of the infection has caused a depletion of water-soluble vitamins.

**Administration**—Minimum daily dose is 250 mg. every 6 hours preferably after meals.

#### TRANPLEX

**Manufacturer**—Elliot-Marion Company Ltd., Montreal 28.

**Description**—Each tablet contains: Thiamine 2.5 mg., riboflavin 2.5 mg., niacinamide 25.0 mg., calcium pantothenate 5.0 mg., pyridoxine 0.5 mg., folic acid 0.5 mg., ascorbic acid 75.0 mg., vitamin B<sub>12</sub> 1 mcg., vitamin K 0.5 mg., reserpine 0.1 mg.

**Indications**—As a tranquillizer and to provide for extra water-soluble nutritional factors in stress conditions.

**Administration**—One tablet 4 times daily.

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**Manufacturer**—Pfizer (Canada) Ltd., Montreal 9, Que.

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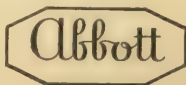


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# THE CANADIAN NURSE

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## Our Senior Citizens

**D**URING THE PAST TEN YEARS there has been a growing awareness of the problems of our senior citizens. We in the field of nursing must not be concerned only with the medical and psychiatric needs of our older citizens, but rather with their over-all needs.

What are the over-all needs of the older age citizen? They are:

Good medical and psychiatric service to maintain and increase health as well as prolong life.

Adequate living arrangements and pleasant family or home relationships.

Opportunities for emotional security and social usefulness.

Opportunities for financial security upon retirement.

Opportunities to work and earn commensurate with ability to do the job.

Opportunities for continuation of creative activities or guidance in the positive use of leisure time.

Opportunities for making new friends since many outlive their friends or spouse.

Facilities for the care of the chronically ill.

These are the very same goals we set for ourselves throughout all of our stages of life, but to the older adult they become matters of deep concern.

Since increased age is linked closely with increased susceptibility to chronic illness, medical and nursing costs will rapidly increase as more and more people live longer. We, in the nursing profession, will have to realize that failing powers increase insecurity and tend to produce a reaction to enforce the claim of the person for the care



(Mathews)

MARY E. WILSON

and attention which he is in fear of losing. Many visits to the clinic and the physician are expressions of this constant search for reassurance.

The opportunities for older workers in our economy has steadily declined. In 1900 about 60 per cent of our senior citizens were in the labor force. Today this figure has declined to approximately 45 per cent. Broad social legislation such as a Social Security Act in conjunction with a program aimed at furnishing work opportunities based on ability rather than age could relieve some of the obvious economic problems of the senior citizen. But the challenge of older age cannot be dealt with merely through meeting the economic wants of man.

We must recognize that recreation is one of the basic human needs at all ages. The philosophy of recreation for older individuals implies that the older person should have the opportunity to socialize and take his place, secure within his own age group. Further, he should have the opportunity to remain an integral part of the community in order to be able to participate in all types of activities with people of all ages.

There is need to provide sheltered care for some older persons. Such care should be provided on the basis of their needs and desires, as well as upon the advantages to them and the state afforded by the particular living arrangements. Those who live in institutions should not be isolated and cut off from life, but in some fashion their life should be a continuation of normal living, with its contacts and activities. In providing protective en-

vironments for our senior citizens we should be concerned with pleasant and safe surroundings, good food, pleasant associations and the stimulation of interesting events and useful things to do.

No attempt has been made to explore all the avenues of this vast and complex problem. These brief remarks were made with the hope that nurses might see more clearly where they could contribute to programs being planned for the health and welfare of our senior citizens.

Nurses can render invaluable assistance by serving on committees that are making plans for the future; by assisting in the institutes and conferences now being conducted; by devoting some time on the programs of their professional organizations to the consideration of the problems that are inherent in old age, and by encouraging the establishment of courses of study which will help them to prepare for this important phase of nursing care. We can help to stimulate the development of ways and means to provide rehabilitation and recreation programs especially for those who are confined to their homes. As nurses and citizens we have a real responsibility to do all we can to ensure adequate care for the aged, whether it be in hospitals, nursing homes, or in their own homes. Let us not shirk this responsibility. Let us truly say, "We serve our Senior Citizens."

MARY E. WILSON, B.Sc.  
*President,  
Manitoba Association of  
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## Studies of Patient Care

The American Hospital Association and U. S. Public Health Service have jointly sponsored studies of patient care in 50 general hospitals. One purpose of these studies is to determine to what extent the number of hours of nursing care provided each patient contributes to his satisfaction with his hospital stay. Another objective is to find out what nurses and other members of the hospital staff think about the nursing services they are able to provide. From the facts obtained, the participating hospitals expect

to develop ways of improving patient care.

On a single day in each of the 50 selected hospitals, doctors, nurses, other personnel, and all patients who are well enough will fill out questionnaires stating frequent or infrequent causes of dissatisfaction with nursing. Participation is entirely voluntary and the completed questionnaires will be anonymous when they leave the hospital for analysis.

— U. S. DEPARTMENT OF  
HEALTH, EDUCATION & WELFARE



# The Management of Lumbar Intervertebral Disc Lesions

HAROLD J. ROSEN, M.D.,  
F.R.C.S. (C)

IN THE NORMAL ADULT an intervertebral disc separates each pair of vertebral bodies of the spine, from the second-third cervical to the fifth lumbar-first sacral levels inclusive. Although lesions of these intervertebral discs are possible at any level — cervical, thoracic or lumbar — they are more commonly significant from the neurosurgical operative standpoint when they involve one or more of the discs in the lower cervical or lower lumbar regions. In this presentation the discussion will be confined to lesions of lumbar intervertebral discs.

The recognition of lumbar disc pathology as a frequent cause of low back and lower limb pain and disability is a relatively recent event. The operative treatment of such lesions, in significant numbers, only began to be reported in the late 1930's and early 1940's, but within recent years posterior protrusion or rupture of lumbar discs has come to be the condition most often treated by neurosurgeons. The condition, of course, existed previously, but in most such patients it was labelled as "lumbago" or as "lumbago with sciatica" — terms which are really only proper names for the symptoms usually reported by these patients, rather than actual pathological diagnoses — and only conservative measures of treatment were prescribed.

## ANATOMY AND PATHOLOGY

The intervertebral disc, normally conforming in outline to that of the two vertebral bodies which it separates, consists of two portions. The outer lamellated fibrous portion is called the *annulus fibrosus* and the softer homogeneous centre has been named the

*nucleus pulposus*. A thin plate of hyaline cartilage separates the surface of the disc from the bone of the adjacent vertebral body. The mid-portion of the anterior and posterior aspects of the disc (and of the vertebral bodies as well) is supported by two strong ligaments, which run along the entire length of the spine, and are termed anterior and posterior longitudinal ligaments, respectively. Other structures to be mentioned in this regard are the *ligamenta-flava* (Yellow ligaments) running between the laminae of the posterior vertebral arches; the tough fibrous tissue forming the capsule of each lateral articular joint (the inner part of which is an important element in determining the size of the adjacent intervertebral foramen); the extradural fat; and the extradural veins.

Intervertebral disc degeneration is regarded as a process of normal ageing. However, it does seem to occur at an earlier age, and to a greater degree, in some individuals than others. The factors responsible for this variability are as yet far from adequately understood. In some patients trauma, acute or chronic, plays a definite role in this respect, and this will be discussed below. The degenerative process in the disc may be of greater degree either in the annulus or in the nucleus, but in most cases both portions are affected to some extent.

The degenerative changes in the annulus (which, microscopically, appear as fibrillary change, abnormal pigmentation and nuclear swelling) result in a weakening of this structure, particularly of its thinner posterior part. This weakening permits a herniation of changed fibro-cartilaginous and nuclear disc material beyond the normal confines of the disc. The herniation may be incomplete, forming a "bulge," or complete. It is then termed a "seques-

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tration." When the nucleus pulposus is the seat of the major degree of the degenerative process, it is usually in the form of an abnormal dessication. The nucleus decreases in volume, and then the weight of the individual causes a bulging of the relatively unsupported annulus in all directions.

When the above-described events take place gradually, a series of so-called "secondary changes" result. At times these secondary changes are of great importance in explaining the patient's symptomatology. Thus, with the loss of volume of the involved disc, the spinous processes, laminae and articular facets of the adjacent vertebral arches tend to override one another to an increasing extent. The ligamenta flava and capsules of the lateral articular joints tend to thicken. Some or all of the adjacent bony structures may show hypertrophic osteophytic formations, as a result of the disturbance of their periosteal layer. The normal extradural fat may be replaced by a variable amount of scar tissue, containing dilated blood vessels. At times a portion of the disc material finds its way into the substance of the adjacent vertebral body, by-passing the degenerated cartilaginous plate, to form a so-called "Schmorl's node."

As mentioned above, trauma is often a factor in causing rupture of a lumbar intervertebral disc. A previously normal disc may be disrupted by severe trauma to the spine. On the other hand, a lesser degree of trauma may result in a clinically significant protrusion or rupture of a previously degenerated disc. The damage is usually produced by a strain in flexion. The herniation may occur at the time of injury or later, depending on the direction and force of the trauma and the state of the disc at the time. Frequently, subsequent and even mild injury, as in bending, coughing or sneezing, or straining at stools, increases the herniation.

Protrusion of the disc into the spinal canal causes back pain, probably by stretching the posterior longitudinal ligament. If the protrusion is sufficiently extensive, it impinges on the adjacent nerve root somewhere between its point of emergence from the dural sac and its exit from the intervertebral foramen, with resultant pain,

weakness and numbness in the area supplied by that particular nerve root. It should again be noted, however, that in the more chronic case many of the symptoms reported by the patient are due to the above-described "secondary changes" in the adjacent structures of the spine, rather than entirely the result of the abnormal position of a portion or all of the involved disc.

With few exceptions, lumbar disc lesions involve the fourth (L4-5) and/or fifth (L5-S1) discs, the incidence of the two being approximately equal. Both may be affected in the same patient, either simultaneously or at different times. Protrusions of the third (L3-4) disc constitute about 2 per cent of such cases, and in only a negligible number of patients is a clinically significant lesion of the first (L1-2) or second (L2-3) disc encountered.

#### CLINICAL PICTURE

The "typical" patient with a posterolateral protrusion of one of his lower lumbar intervertebral discs usually dates his symptoms, or at least their acute exacerbation, from some incident in which he strained his lower back while in a partially flexed position. For example, he may report having carried a heavy weight with another person who unexpectedly dropped his end; or he sustained a fall on the spine in the sitting position. On the other hand, in the more chronic case, the patient may be unable to recall a single specific injury. The pain, sharp in quality, is in most cases confined to the lower back at first, either in the midline, or to one side of the midline in the lumbo-iliac region. Later the pain radiates, first into the region of the "hip," and then down the back of the thigh and outer aspect of the leg, ending either at the ankle, or the dorsum of the foot, or in one or more of the toes of the foot, depending on the nerve root or roots involved. When the nerve root compression and consequent pain are severe, the symptoms are increased by trying to bend, or to straighten up when standing, by turning in bed, by coughing, sneezing, straining at stool, etc. A feeling of tingling and numbness, more or less in



the distribution of the radiating pain in the lower limb, is frequently present, either intermittently or continuously. Rest, particularly on a firm bed or on the floor, usually gives some relief. As a rule, the symptoms are intermittent.

The patient walks warily, perhaps with a limp, favoring the involved leg and bent slightly to moderately forward and toward the side away from the involved nerve root. When he sits down, he does so carefully, staying off the involved buttock, keeping his back rigid and leaning backward, with the affected leg stretched out a little, but flexed at the knee. The standing posture reveals a variable degree of dorso-lumbar scoliosis, diminution or loss of normal lumbar lordosis, and tilting of the pelvis, with associated spasms of the lumbar paraspinal muscles. To palpation there is tenderness over the 4th or 5th lumbar interspace and along the distribution of the sciatic nerve on the involved side. Straight leg raising with the ankle at right angles is impaired, more so with the affected leg.

The above so-called "orthopedic signs" do not localize the lesion to a particular level. On the other hand, the neurological signs are often helpful in this respect. Thus, when the protrusion is at the L5-S1 level, compressing the S-1 nerve root, the pain and tingling usually extend to the little toe side of the foot; the motor weakness involves the gluteal and hamstring (and perhaps calf and extensor hallucis longus) muscles; the sensory deficit is in the distribution of the S-1 nerve root, including the lateral margin of the foot and little toe; and the ankle jerk is relatively diminished or absent. When the protrusion is at the L4-5 level, compressing the L-5 nerve root, the pain and paresthesia may extend to the middle three toes of the foot; the anterior tibial muscle is the one most strikingly weakened (resulting in a partial or even complete drop-foot); the sensory deficit is in the L-5 dermatome area, possibly including the middle three toes of the foot; and there is usually no disturbance of either the knee jerk or the ankle jerk. Indeed, it should be noted at this point that, in the atypical case, evidence of neurological deficit is most likely to be absent,

even when the nerve root is significantly involved and there is a great deal of pain. In the much rarer patient with a protrusion at L3-4, compressing the L-4 nerve root, the symptoms may extend into the big toe of the foot; the focal motor weakness is greatest in the quadriceps muscles; the sensory deficit is in the L-4 dermatome distribution (with possible inclusion of the big toe); and the knee jerk is the reflex which is diminished or even absent.

#### PLAIN X-RAY EXAMINATION

Although it is true that a disc protrusion is itself not visible in the plain x-rays of the lumbo-sacral spine, much valuable information may, nevertheless, be gained from a careful study of such x-rays, particularly from the standpoint of differential diagnosis. There is usually confirmation of the clinical evidence of the loss or diminution of normal lumbar lordosis. Narrowing of the disc interspace and associated hypertrophic bony changes can be expected only after the condition has existed for many months. More importantly, one looks for evidence of spondylolysis or other anomalies of the spine, bony injury, pressure changes due to intraspinal tumor, bone destruction, etc., all of which may result in symptoms and signs simulating those of lumbar disc protrusion with nerve root involvement.

#### MYELOGRAPHY

It is the author's opinion that myelography is a necessary adjunct to the investigation of the patient when operative intervention is being seriously considered. It is true that the symptoms and signs are often sufficiently definite to localize the lesion accurately without myelography. It is also true that in the majority of patients the lesion will be found at the L4-5 or L5-S1 level. However, there are sufficient exceptions to these general rules to warrant the additional help of a myelogram before proceeding with the actual operation. Possible reasons for deviation from the "typical" clinical picture are:

Lesions at more than one level; far lateral protrusions; unusually large pro-



trusions; lesions other than protruded discs; and the presence of a state of so-called "pre-fixed" or "post-fixed" plexus, with or without an associated abnormality in the number of lumbar vertebrae, and with resultant variance from the normal as to the parts supplied by each nerve root.

It is, of course, recognized that the myelogram is not always helpful, since a far lateral disc protrusion or a wide spinal canal may result in failure to demonstrate a defect in the oil column; also various artefacts may be misleading. Nevertheless, in conjunction with the remainder of the clinical picture, the myelogram is more often than not a great help in planning the nature and extent of the operation beforehand. At the Saint John General Hospital the oil, Ethiodan, is being used for myelography at the present time. Every effort is made to achieve a complete removal of the oil at the conclusion of the examination.

#### CONSERVATIVE TREATMENT

Many patients with lumbar disc lesions can be managed successfully with conservative measures alone. This applies particularly to individuals with mild disc protrusions situated at one or more levels of the lumbar spine, and developing over a long period of time. An episode of exacerbation of symptoms in such a patient may require a period of rest on a firm bed, usually with the help of a board between mattress and spring. In rare cases traction is of help in managing the acute pain, though usually when traction is necessary operative intervention has to be more seriously considered. For severe muscle spasm, muscle-relaxing drugs may be relieving, but, often, frequent warm baths are a more effective treatment in this respect. Most important of all in the long-term management of such a patient are:

- (1) A regime of low back exercises, usually of the extension type, carried out *regularly*, at least twice daily (e.g., on arising and before retiring); and (2) constant attention to proper posture, when relaxing, during work, and at play.

In the latter respects, the individual should try to avoid straining his back in a flexed position; he should make

every effort to bring his work "up to his level," rather than bending down over it; and he should confine his "play" to activities in which his movements are predictable and controllable at all times, avoiding activities which might demand sudden movements of his spine for which he is not prepared. In general, the maintenance of proper posture should become an integral (and probably "subconscious") part of the patient's existence, so that he lies, sits, stands and walks "tall" at all times — and even begins to demand that his fellowmen and women do the same.

The wearing of a back brace is seldom if ever a necessary part of the conservative program. The patient who performs the exercise regime regularly will develop his paraspinal musculature into a very effective bracing mechanism. On the other hand, the wearing of an artificial brace often encourages exercise laziness, and results in flabby back muscles, which are incapable of adequately protecting the levels of the spine weakened by the disc degenerations and protrusions.

#### OPERATION

The problem of "when to operate" now comes up, and it is not easily clarified. Each patient must, of course, be evaluated individually. An effort is made to handle most early cases conservatively. In general, operation is advised for one of two reasons.

Firstly, the patient presents a picture of pain that is continuous and severe, in spite of all conservative treatment, and there is clearcut neurologic deficit, indicative of significant nerve root compression. This applies even to the patient with a "first attack" of relatively recent onset.

Alternately, there have been recurrent episodes of temporarily incapacitating pain, which, though remitting after a variable length of time, occur with sufficient frequency (in spite of continuation of adequate conservative treatment) to significantly limit the individual's capacity to work and "live a normal life." Such a patient may not exhibit much neurologic deficit on examination.

In the author's experience, as mentioned previously, the disc lesion in

such cases is more often at L4-5 than at one of the other lumbar levels. As a general rule, a patient should be operated upon during an acute attack or an extended bout of pain but sometimes this rule must be modified to suit the patient's convenience in relation to his or her occupation.

In this presentation the operative procedure need not be discussed in detail. Suffice it to say that it should entail adequate exposure; thorough removal of the abnormal disc (not only its protruding portion), including the cartilaginous plates, so that raw bone is left above and below; careful lysis of the compressed nerve root, with excision of the extradural scar tissue; and decompression of the intervertebral foramen in certain cases. Adequate curettage of the disc interspace often results in at least partial fixation of the joint by subsequent ingrowth of firm scar tissue; indeed, in some cases bony fusion eventually takes place in this way. A formal bone graft fusion, or any other attempt at partial fixation of the level or levels of disc removal, should not be considered as part of the primary operation for lumbar intervertebral disc protrusion. Spinal fusion should be considered as a phase of the treatment of certain patients on its own merits, and can usually be reserved for a future date, at which time the decision is made on the basis of specific detailed indications that have to do only with the fusion. Fortunately, in the vast majority of these patients it never becomes necessary.

#### POSTOPERATIVE MANAGEMENT

The postoperative routine varies a good deal with the individual surgeon. On the Neurosurgical Service of the Saint John General Hospital the average post-discectomy patient is mobilized in and out of bed as soon after the operation as possible. Often he will stand beside his bed to void, if necessary the evening of the operative day. He is helped in turning from side to side once each hour. He is encouraged to at least stand up, or even to take a few steps, the first postoperative day. Thereafter, his mobilization progresses rapidly. At the same time he is maintained on a graduated regime of lum-

bar tension (extension) exercises, which in most cases he has already learned, to a greater or lesser extent, before operation. The skin sutures are removed on the fifth or sixth postoperative day. The patient is usually ready for discharge from hospital on the tenth postoperative day, by which time he is up and around most of the day and doing the lumbar exercises at least four times daily.

In the patient's early postoperative treatment the nurse's role is of particular importance. It is she who should be responsible for encouraging the patient to turn in bed, despite the associated discomfort, and in his subsequent gradual mobilization out of bed, and resumption of the exercise regime. It is the author's conviction that this early activity does no harm, and certainly does much to speed the patient's convalescence, particularly in regard to preventing or overcoming the uncomfortable muscle spasms that sometimes appear in the lower back, the "hips," or in the lower limbs themselves. Moreover, it gives the patient an early confidence in his ability to use his back again, and in this way inspires an earlier return to gainful employment.

After discharge from hospital, the patient is advised to continue his convalescence at home for another month, doing the tension exercises four times daily, and gradually assuming additional activities around the house. Office work is allowed after this first month. Patients with more strenuous jobs are usually ready to return to them within three months after operation. It is recommended that lifting be done, as much as possible, "with the legs," keeping the back straight. Really heavy lifting is probably never advisable; nevertheless, many lumbar discectomy patients have of necessity returned to maximum laboring jobs, such as stevedoring, without apparent trouble. All of these patients are followed periodically for at least a year after operation. The "attention to posture and regular exercise routine," outlined above for the conservatively-managed patient, applies equally to the post-discectomy patient, and this fact must be stressed to both, again and again.



## CENTRAL LUMBAR DISC PROTRUSION

Most of the above applies particularly to lateral protrusions of lumbar discs. In comparison to lateral protrusion, central disc protrusion or rupture is relatively rare, probably because of the thickness and resistive strength of the posterior longitudinal ligament in the central part of the spinal canal. On the other hand, a patient with a mild central protrusion is not as likely to come to the attention of a neurosurgeon as a patient with a lateral protrusion of similar degree, but with impingement on the adjacent nerve root.

Central disc protrusion without significant compression of the contents of the dural sac usually results in back discomfort only, and a longer period of conservative treatment, as outlined above, is usually indicated. However, if the pain continues to be severe and recurrently incapacitating, operative intervention, preceded by myelography, must be more seriously considered.

In a few cases, a relatively large portion of the intervertebral disc ruptures into the spinal canal, compressing the nearby cauda equina. This may result in major neurologic deficit in the lower part of the body, including marked muscle weakness in the lower limbs; "saddle anesthesia," and loss of bladder and bowel sphincter control. Myelography usually demonstrates a

complete obstruction of the canal at the level of the ruptured disc in these cases. Operation to relieve the obstruction and compression is urgent, if permanent neurologic deficit is to be avoided.

## RESULTS OF OPERATION

Surgical removal of protruded lumbar discs has become a safe and satisfactory procedure. Nearly all patients, if selected carefully for the operation, are benefited by it, at least to some extent. In most reported series more than half of the patients have been relieved of all their symptoms; usually close to 90 per cent are entirely relieved of the lower limb pain; persistent back discomfort may be reported by as many as 40 per cent of these patients, but it is of slight degree in the majority of this group, particularly if they maintain their exercises regularly. Less than 1 per cent of a properly assessed and properly operated series of patients may be no better following the operation.

Finally, in order to end this discussion on a positive rather than a negative note, I shall repeat the previous sentence in reverse — that is, more than 95 per cent of a properly assessed and properly operated series of patients with lumbar disc protrusions may be expected to improve, at least to some extent, following operation.

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Thirty-millionths of one second is to most people a meaningless fraction of time, seemingly impossible to measure. Yet, electrical pulses this short are produced by a new machine for the stimulation of the brain. For years, scientists have sought a way to treat the brain safely with electrical current, but until the invention of this machine any current strong enough to stimulate would damage the brain if used for an extended period of time.

The new device discharges two electrical pulses — one back and one forward flow of current, with the second cancelling the effects of the first because a one-way flow will damage the brain. Since the pulse durations are only thirty-millionths of a second, further danger is eliminated. The inventors have used the machine successfully

to stimulate the outer layer of the brain of a monkey for four to five hours a day up to seventeen weeks with no harmful effects. They believe their invention will be of great assistance in the examination and treatment of the human brain. — (ISPS)

\* \* \*

Ideals are like stars; you will not succeed in touching them with your hands, but like the seafaring man on the desert of waters, you choose them as your guides, and, following them, you reach your destiny.

— CARL SCHURZ

\* \* \*

Perseverance is a great element of success. If you only knock long enough and loud enough at the gate, you are sure to wake up somebody.

— HENRY W. LONGFELLOW



# Nursing Care of Patients with Lumbar Intervertebral Disc Lesions

DONALDA MAC TAVISH and DOROTHY MACQUARRIE

ON ADMISSION, the patient with a suspected disc protrusion in the lumbar area is usually having severe pain in the low back region and/or either or both legs. There may also be some numbness in the affected leg, or possibly a footdrop. Frequently, the symptoms are more pronounced during the night.

Each patient generally has his own method of relieving the pain temporarily. We also have several procedures that can be tried in this respect. Applying manual traction, such as pulling on the patient's legs, often provides temporary relief. It is not unusual to give the patient a warm tub bath at any time of the day or night to help relieve the pain. Exercising or merely walking about may be necessary, and is often effective. We do not use the application of external dry heat as a method of relieving pain in our department mainly because of the danger of burning areas in which there is decreased sensation. The analgesics that we use and find most effective are a combination of aspirin 5 gr. and phenacetin 5 gr., or aspirin compound with codeine  $\frac{1}{8}$  gr.

## DIAGNOSTIC PROCEDURES

*Laboratory tests* carried out are:

- Urinalysis
- Blood Wasserman
- Red blood cell count
- Hemoglobin
- White blood cell count and differential
- Sedimentation rate
- Cerebro-spinal fluid for differential cell count, protein content and Wasserman reaction.

*X-rays:*

- Of lumbar spine and pelvis
- Of chest. (Occasionally chest x-ray)

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for rib count, where there is a question of an unusual number of vertebrae

A myelogram is done.

The myelogram is usually an important factor in the doctor's decision regarding treatment. This procedure is done in the x-ray department. With the patient lying face down on the x-ray table, a spinal puncture is done in the lumbar area. Radio-opaque oil (8-10 cc.) is injected intrathecally after the removal of 10 cc. spinal fluid. The x-ray table is tilted, allowing the oil to move up and down the spinal canal. This column of oil is followed by the radiologist with a fluoroscope. A repeated interruption or partial indentation in the column of oil designates pressure on the subarachnoid space. Permanent x-rays are taken of all areas.

Following this procedure, the patient is returned to his room and placed on his abdomen for one hour. After that time, he is allowed up and about as desired. We check on the patient's first voiding following a myelogram. Sometimes a suboccipital headache, of varying severity, follows the procedure. This headache can last for as long as ten days. Lying flat in bed may provide adequate relief, but sometimes caffeine sodium benzoate is tried. The patient should be encouraged to force fluids during this time. Other methods of relieving headache, such as the application of ice-caps, etc., may be used.

## TREATMENT

*Exercises:* In most cases, lumbar tension exercises are started shortly after admission. These are done once daily under the supervision of the physiotherapist, and the patient repeats them on his own at least three more times during the day. These exercises consist of general tension, straight leg

raising, head and shoulder lifting, combinations of the last two, bicycling, etc., with the patient in various positions. They are continued until operation and then resumed gradually after operation. Sometimes physiotherapy is the only treatment necessary.

*Preoperative care:* When operation is indicated, the preoperative preparation is similar to that for any other surgical procedure. Blood is taken for grouping and crossmatching, and ordered for transfusion during or after surgery. A large area of the back is shaved. It is scrubbed with phisohex for five minutes at least twice on the day preceding operation and once the following morning, shortly before operation. The preoperative sedation is usually morphine or demerol and hyoscine.

*Postoperative care:* If the patient has had a general anesthetic, he is placed in his bed in a semi-prone position, with a pillow placed lengthwise under his chest and abdomen, and another pillow under the uppermost leg, which is slightly flexed. If the patient is conscious (and he usually is, as spinal anesthesia is favored), he may be placed on either side, with a pillow supporting his back, another between his legs, and a small pillow under his head.

The temperature is taken rectally for three days postoperatively or until normal; we use the rectal method because it is the most accurate. If the temperature is subnormal we apply the bed-warmer, which blows warm air over the patient's body, between the sheet and bedspread.

The blood pressure, pulse and respirations are checked immediately upon return to the room, and re-checked frequently until the following day, or until stable. If the blood pressure falls below 100 mm. systolic, the foot of the bed is elevated. If a drop in blood pressure persists, intravenous fluids or blood transfusions may be ordered.

The dressing is observed carefully for oozing, and is reinforced and reported as necessary.

We compare complaints of pain as to severity and similarity with preoperative pain, and record any change in sensation or movements of extremities.

We check the time and amount of

the first voiding. If the patient is unable to void, it is usually permissible for him to stand by the side of the bed with assistance. If this is ineffective, prostigmine (or a similar drug) may be given. If the patient is still unable to void catheterization may be necessary. This difficulty in voiding may be due to the spinal anesthetic or it may be a more serious result of the operation.

The patient with a lumbar disc removal is turned from side to side, in a face-down position, every hour day and night. He is encouraged to help himself as much as possible. These frequent turnings prevent stiffness. His hips often become tired and sore. Frequent alcohol rubs may alleviate this.

The preoperative pain may persist in varying degrees for some time following operation. If this occurs, we reassure the patient that the damage to the affected nerve root cannot disappear at once, and give analgesics as ordered and required. Sometimes muscular cramps develop in the patient's legs. Exercising, manual traction, or walking will often relieve these spasms.

The bed is kept flat and the patient is taught to keep his back straight when lying down, sitting or standing. We also teach him to get out of bed by sliding out, face downward, and to come to an upright position with the aid of his arms and hands. In most cases, if not otherwise contraindicated, the patient is allowed up the day following operation. As he becomes stronger, exaggerated knee-bending is encouraged when he is walking.

The dressing is changed by the doctor on the first postoperative day, and every one to two days subsequently until the wound is healed. To minimize the danger of infection, aseptic technique is carried out to the extent of gloves and masks being used. All our dressing changes are carried out in a special treatment room, and not on the ward itself.

As mentioned previously, the tension exercises are continued, and the patient is advised to continue doing them following discharge from hospital. Those who do these exercises faithfully make the best recoveries.

The diet seldom presents a problem. A regular diet, supplemented by vitamins, is resumed on the first post-operative day. These patients rapidly regain weight lost during their illness.

They are usually discharged ten days postoperatively.

#### CONCLUSION

When we started this paper on the nursing care of patients suffering from lumbar intervertebral disc protrusion, we thought it would amount to little

more than one paragraph, since most of our patients have had such uneventful recoveries, and, being hardy Maritimers, have required little actual nursing care. However, once we started, we did find that there are many details to a satisfactory nursing regime for them. One factor which minimizes our work and the burden of instructing these patients is the fact that there are usually several of them in one room. They console, criticize, encourage and compete with one another to a speedy recovery.

## Winnipeg, the Friendly City

WINNIPEG TODAY is a city of broad streets, far-flung residential areas, many parks and clean, handsome buildings. Its geographic position is unique. It lies in a great plain, midway between Lake Winnipeg and the international boundary, and is like an enormous spout through which all the trade between eastern and western Canada must flow.

It is a truly cosmopolitan city. Transplanted Englishmen play cricket in Assiniboine Park, street names recall the Scottish origin of the pioneer

settlers. In the North End Market, Polish women in *babushkas* tend their vegetable stands; the Byzantine spires of Ukrainian Churches rise beside Jewish synagogues; and restaurants specialize in Italian, Chinese or Viennese food.

Fourth largest city in Canada and chief manufacturing centre of the west, it is known for its Musical Festival, its Royal Winnipeg Ballet, its fine hospitals and clinics, and as the home of the University of Manitoba.

Winnipeg's history may be said to



Fountain in Central Park, Knox Church in the background

(C.P.R. Photo)





*Civic Auditorium, Winnipeg*

go back to 1738, for in that year was erected the first building on its future site. This was Fort Rouge, built on the orders of Pierre Gaultier de la Verendrye, explorer and fur-trader of Old Quebec. Fort Rouge, which stood near the junction of the Red and Assiniboine Rivers, was abandoned early and is said to have been followed by a number of other forts near the same spot. No trace of them now remains.

Sometime during the first decade of the 19th century — the dates given vary from 1804 to 1810 — the North West Company established Fort Gibraltar at the Forks. Shortly afterwards, in 1812, the first group of settlers reached Red River. Scottish crofters and fisherfolk, they were brought to the new land by Thomas Douglas, Earl of Selkirk. In spite of many early hardships, the little colony endured and became the nucleus of Winnipeg as a settled community.

In 1821 the Hudson's Bay and North West Companies united under the name of the former. Then began almost half a century of rule by the Company, during which time its word was law over the Canadian northwest. Meanwhile, the Red River settlement — isolated in mid-continent and accessible only by long travel — existed in comparative contentment and prosperity.

Photographs on this and following pages by courtesy of Manitoba Travel and Publicity Bureau.

Near what is now the heart of Winnipeg's business district stood Fort Garry, the Hudson's Bay's headquarters in the west. The settlers' farms extended down the Red, each with a narrow frontage on the river. Beyond them were the handsome stone residences of retired company officials. The largest element in the settlement, however, was made up of the Metis, mainly descendants of French Canadian voyageurs and their Indian wives. They had small farms on the Red's east bank, where St. Boniface now stands, but were concerned mainly with buffalo hunting.

In 1869 it was decided that the district of Assiniboia, which included the settlement on the Red, should be annexed to Canada. The Hudson's Bay Company agreed to relinquish its right of government but from the Metis came determined opposition. Foreseeing the end of their nomadic prairie life, they demanded that the transfer take place only after Red River citizens were guaranteed certain rights. In this they were supported by many white members of the settlement.

Under Louis Riel, Metis forces occupied Fort Garry, seizing its ample stores of food and munitions. A provisional government was established and a List of Rights drawn up. In May 1870, a bill incorporating most of its points was passed by the Dominion Parliament. On July 15, Manitoba formally became a province of

Canada. A month later troops arrived from the east to restore order.

Winnipeg, with a population of approximately 4,000, was incorporated as a city in 1873 although it was then a frontier town of wooden buildings and muddy streets. Five years later a railway was completed, linking St. Boniface with a United States line.

With the completion of the Canadian Pacific Railway, spanning Canada from coast to coast, and a growing realization of Manitoba's potentialities as a grain-growing region, development of the province and its capital city was rapid.

#### UNIVERSITY OF MANITOBA

On the outskirts of Winnipeg, seven miles from the city's downtown district, lies a cluster of buildings — some strikingly modern in design, others of traditional style — which make up the University of Manitoba. In summer the campus is a pleasant spot, where the green foliage of trees contrasts with the grey of Manitoba's famous Tyndal stone. The present University, with its more than 5,000 students, is a far cry from the log house in which Father Joseph Provencher opened the school which later became the west's first college.

In 1818, when the young priest

came to Red River, he found a scattering of settlers' homes. The chief buildings in the little colony were Fort Gibraltar, the North West Company's trading post, and Fort Douglas, headquarters of the Selkirk settlement. On approximately the spot where St. Boniface Basilica now stands, he set about building a combined house and church. Here he began his teaching.

Father Provencher's school did not operate continuously for some time. Devastation of the crops by grasshoppers four years in succession drove many settlers from Red River to Pembina, the log-shack village of the Metis buffalo hunters. Then, in the spring of 1826 the settlement experienced a disastrous flood. The year following, however, Red River finally saw a measure of prosperity and the school commenced to receive boarding students. This may be regarded as the beginning of St. Boniface College.

The origins of Winnipeg's other denominational colleges, which preceded the University, were equally humble. In 1820 the Hudson's Bay Company sent out the Rev. John West, an Anglican clergyman, to minister to the religious needs of the Selkirk settlers. With him came George Harbidge, a schoolmaster. By 1822, a log mission, which served as both church and school, had been opened near the



*Science Building, University of Manitoba*





*Maternity Pavilion at Winnipeg General Hospital*

site of the present St. John's Cathedral. In time the settlement possessed three more schools and the original establishment, grown in importance, offered training of a more advanced type. The first Bishop of Rupert's Land, Bishop David Anderson, named it St. John's College in 1849.

In the same year the Presbyterian settlers in Kildonan erected a log school house just north of where Old Kildonan Church stands today. This building was later replaced by one of stone and here, in 1871, Manitoba College was founded. These three church colleges — St. Boniface, St. John's and Manitoba — formed the nucleus of the University, when the act establishing it was passed by the Manitoba Legislature in 1877.

At that time, only seven years after Manitoba had become a province and more than a year before the first railway was completed to the west, vast difficulties appeared to stand in the way of such a development. The population totalled little more than 25,000 and of this number, less than 10,000 were white. There was not a single high school or collegiate institute in the province, all secondary education being in the hands of the colleges. Again, the creation of a university demanded from the colleges much mutual understanding and concession.

It was largely through the efforts of the Hon. Alexander Morris, then Lieutenant Governor, that the difficulties were overcome and that Manitoba acquired at such an early date the framework of a university. By establishing one degree-conferring body in the province, the Act ensured that a uniform standard of excellence in higher education would be maintained.

Manitoba's University at first possessed no buildings, since the institutions gave no instruction. Teaching was carried on by the affiliated colleges, while the University of Manitoba set and marked examinations and conferred degrees. In 1900, however, an amendment to the University Act gave the institution power to offer instruction. Four years later teaching commenced in what is now known as the Old Science Building on the Broadway site. In 1929 the site of Fort Garry, already occupied by Manitoba Agricultural College, was chosen as the permanent location of the university.

Throughout the years the variety of degree courses offered in the field of arts and sciences has been increased. New faculties and schools have been founded, with even Slavic studies and a course in Icelandic literature added to the curriculum. Today the university offers a multitude of degree courses in the faculties of medicine,



engineering and architecture, agriculture and home economics, education and graduate studies and research, and the Manitoba Law School. Affiliated colleges now are: St. Boniface, St. John's, United, Manitoba Law School, St. Paul's and Brandon College in Brandon, Manitoba. The School of Nursing has not yet reached the level of degree granting but is an integral part of the university.

It is interesting to note that the university is only a little younger than the city itself for the Act establishing the former was passed only four years after that which incorporated the city of Winnipeg. Since those far-off days of the last century, the two have developed together — Winnipeg into a thriving metropolis and the university into the fourth-largest English-speaking university in Canada.

## We Cannot Come Down

IONE E. SPALDING, S.R.N.

TO SPEAK ON PROFESSIONAL IDEALS is like attempting to catch Niagara Falls in a medicine bottle — the scope of such a subject is tremendous and the possible avenues of approach almost unlimited. I shall therefore restrict my treatment of the subject to definition and consider exactly what we mean by the word "professional" and the word "ideals," fitting the findings into the professional world as a whole, for nursing has shared with the other great professions a tradition of service to society based not only on personal reward but also on personal obligation.

The Oxford Dictionary defines profession as a *vocation in which a professional knowledge of some department of learning or science is used in its application to the affairs of others*. If this is so (and who dare doubt the Oxford Dictionary!) what a challenge any member of any profession accepts when he claims professional status! Before we reach our second word "ideals," we are brought right up against vocation and the professing of a knowledge which it is our duty to apply practically — to the affairs of others.

This excellent paper is an abstract of an address delivered by Miss Spalding to the Liverpool Branch of the Royal College of Nursing. It is adapted to Canadian usage and reprinted from *Nursing Times* with the kind permission of the editor.

### PROFESSIONAL STATUS

The professional man or woman can never be satisfied with the second best — he can never look on his work as *merely* a means of livelihood. Certainly it is through his work that he obtains his livelihood, but the professional man, be he lawyer, doctor or university professor, who could not care less whether his work is indifferently done has no moral right to claim professional status. He is in fact *not* a professional man though he may profess and call himself a doctor, lawyer or university professor.

For the professional man both claims and accepts professional status. That is to say, he expects from society a proper respect (without which he cannot adequately discharge his obligations) and he also accepts a definite debt payable by him to society through the medium of his work, be it law, medicine or teaching. Unless he realizes that he is a debtor to society he cannot claim professional status, for the term implies a particular relationship between him who professes to serve and those served.

Down the ages people have always been sensitive about the question of professional status. The physicians have looked down on the barber-surgeons, the barristers and judges on the attorneys, and today registered nurses may tend to look down on the nursing assistants, and all because the principle of professional status is misunderstood.

Professional status surely implies a certain *relationship*, a right relationship between the professional man and his client (or patient) and between the professional man and his colleagues. To increase a man's professional status from the outside by councils and committees does not in fact augment in the slightest degree the respect in which he is held, or the service which he is able to give. One cannot give a man dignity — a man is *what* he is, what he has made himself, and his true worth cannot be falsified by making him more or less important in the eyes of society or his colleagues.

Consider how common it has been to demand the respect due to professional status without accepting its inherent debt to society. Indeed, laws safeguarding society have been necessary for at least 4,000 years. According to the famous Code of Hammurabi, 2,000 years B.C., a surgeon was liable to have his hands amputated in cases of carelessness or negligence in the operating theatre. Later on, in the 13th century in England, a gentleman of the name of Robert was liable "to be kept in prison in iron bonds, never to go forth" if he failed to complete a certain literary composition which he had undertaken. Poor Robert!

The danger of this present age is that the term "professional status" is coming increasingly to mean the rights and privileges of the professional man at the cost of losing sight altogether of the debt owed by him both to his profession and to society as a whole. Certainly, society must keep its part of the contract — certainly the professional man must be paid his rightful dues of status, authority and privilege, but this depends a good deal on the profession itself and the members who form it.

"I hold everyman," says Francis Bacon, "a debtor to his profession from the which as men do of course seek to receive countenance and profit, so ought they of duty to endeavour themselves by way of amends to be a help and ornament thereto." Now there we have it concisely put. "To receive countenance and profit" of course, says the practical, sensible Bacon, but he also talks of being not only a help, but an ornament to the profession.

It is most essential always to have our feet firmly planted on the ground and our heads screwed well upon our shoulders, but surely if Bacon is right (and we should all agree about the "countenance and profit") and it is our duty to be a help and an ornament to our profession, then, as members of a profession we can claim something beyond material gain, good working conditions, human respect. Surely all who claim professional status must dare to see a little of the everlasting glory and weave something of its splendor into the day-to-day routine of professional life.

### ACTION WITH VISION

This brings us naturally and without effort to "ideals." We know the professional man to be the practical man — words such as skill, applied knowledge, action, belong to him. What then of the professional man at his best? The Oxford Dictionary defines ideals as "answering to one's highest conceptions." Ideally, then, action is not enough; there must be vision out of which action is born. And the limit of our vision determines the limit of our work.

As you know, it is possible to carry out the simplest nursing procedure satisfactorily in two ways — one can dress a painful wound with knowledge and skill and leave it at that; but ideally, to that knowledge and skill can be added the unspoken, hidden compassion of the divine charity. Then nursing becomes not only professional but creative, redemptive, a part of the final triumph over all that wrecks the loveliness of life.

So much then for professional ideals as they affect society. But how do they affect the profession itself? Is it not a distinguishing characteristic of members of a profession that they are, and act as if they are, members one of another? Does not the ethical relationship of each member of a profession to those he serves bind the whole profession together? Ideally both the heads of any great profession and its most junior members are primarily concerned with the same object (client or patient) and therefore they are bound to each other in a desire to cooperate to the full. This is, indeed,



not just a happy thought but an unavoidable debt to be paid by all its members, and is paid in the coinage of true courtesy, for courtesy is the hallmark of professional behavior.

This most attractive quality, courtesy, brings with it a great freedom, for personal likes and dislikes, though they still exist, cease to matter. As members of the same profession we are bound to be courteous to each and all, and courtesy is not courtesy unless it carries with it an *absolute loyalty* behind the scenes.

In summing up these thoughts I would suggest to you that this age presents a challenge to all professions, but most particularly to our own.

#### TRADIMUS LAMPADA\*

Your professional organization is the Canadian Nurses' Association, and while it is vital that your professional organization should defend and protect its members from the evils of injustice, low salaries and poor working conditions, this is by no means the whole story. The Canadian Nurses' Association is also the guardian of your professional standards and the association *is its members*. It is through its members all over Canada that the fight against the second-rate is being waged. The Canadian Nurses' Association, through its members, is the bulwark against that attitude of mind which asks only "What can I get out of life?" *Tradimus Lampada* — we hand on the torch — the torch of knowledge, of skill and above all of compassion, but in the darkness of this material and anxious age, its light must be of such a nature that nothing can overcome it.

From a private diary written about 22 centuries ago by a soldier of some renown come the following words: "I am doing a great work and, therefore, I cannot come down." He is recording his answer to a message sent from enemy headquarters that he should leave undefended the walls of his besieged city and come down to discuss terms with his opponents in the plain below. This sentence surely illustrates concisely and accurately all

that professional ideals signify — "I am doing a great work and, therefore, I cannot come down."

You are doing a great work — for what greater work can there be than that which you are doing? In a world of wars, and rumors of wars, your work never changes. You are always concerned, whether there be war or only its rumor, in the saving of life, not the taking of it; in the relief of pain, not the infliction of it; and for all who see beyond the temperature chart and the next injection of penicillin, a share in the inestimable privilege of passing on not necessarily in words but through the medium of daily routine, whether in the ward, operating theatre or outpatient department, something of the peace which passes understanding.

I am doing a great work and, therefore, I cannot come down. Because I am doing a great work, I cannot come down. I cannot lower my standard. Because I am a hospital nurse or a public health nurse or engage in private nursing, I cannot give less than the best. My patients may be appreciative or unappreciative, likeable or irritating, rich or poor, friend or foe. No matter, I am doing a great work and, therefore, I cannot come down. I cannot give less than the best, and because I am a member of a profession, I cannot work in splendid isolation. I am part of a whole, and I am under obligation to that whole. A profession is a group of individuals linked together by a common bond, not a group of individuals unrelated to each other. The profession gives me my status and my authority; I owe the profession my allegiance.

So then, the harassed head nurse may be driven round the bend by her irritating, clumsy student nurse, and the same irritating, clumsy student nurse may think of the head nurse without any particular affection, but the attitude of both to each other will be courteous and loyal. Gradually, at considerable cost, the right relationship of mutual respect and willing cooperation will be established. Because both are engaged in a great work, ideally neither the head nurse nor the student nurse can come down to the level of personal likes and dislikes; neither will lower her standard and the result will

\*This is the motto of the Royal College of Nursing (United Kingdom).



be well worth the cost. But even this is not enough. As a member of a profession I am under obligation not only to my own hospital and school of nursing but to the profession as a whole. I am bound, therefore, to identify myself with my profession not primarily for what I can get out of it but because I am under obligation to it. Active participation in professional associations is one way in which this obligation may be met. Nor can I rest here! *Tradimus Lampada*, we hand on the torch, and I must hand on both to my colleagues and to my juniors the torch of professional responsibility. For what does the Canadian Nurses' Association really stand for if not to transmit through its members the vision of the greatness of our calling?

### A GREAT WORK

"Where there is no vision," says the Book of Proverbs, "the people perish," and history has proved this to be true. It is equally true that a profession

without vision, without ideals, perishes. Today there is real danger that nursing is losing its ideals. Today the destructive forces of apathy, indifference and insistence upon "my rights" are gaining ground. Not in all places is the patient the centrepiece — the patient for whom the hospitals were built, for whom the medical and nursing staff work and for whose welfare departments of health exist. It is, after all, the individual man in his own right, who matters — John Smith who knows, as some of us may never know, the loneliness of pain and the longing to be a little loved, a little cared for and not just *treated*. Today the red light is on and it is through you, the members of the Canadian Nurses' Association — the heart and home of Canadian nursing — that nursing as a profession and a vocation will survive, for surely the answer to all that is unprofessional and second-rate in nursing today must be the proud claim "We are doing a great work and, therefore we cannot come down."

## Convention Personality

Contributing particularly in conjunction with the special program arranged by the Committee on Nursing Education will be **Mildred E. Schwier**, director of the Department of Diploma and Associate Degree

Programs, National League for Nursing, who has had many years of experience in both the service and educational fields of nursing. A graduate of the Mt. Vernon (N.Y.) Hospital, Miss Schwier received her B.S. in teaching in schools of nursing and her M.A. in administration, both from Teachers College, Columbia University. Her broad professional experience includes a head nurse-ship, nursing arts instructor, supervisor of clinical instruction, educational director and director of nursing. Before joining the N.L.N. she was director of nursing in the General Hospital, Pittsfield, Mass.

Miss Schwier is actively concerned with the development and improvement of nursing education. She assisted in the preparation of a study published by the N.L.N., "Ten Thousand Nurse Faculty Members in Basic Professional Schools of Nursing." In 1951-52, she was the assistant director of the National Nursing Accrediting Service (now the Accrediting Service of the National League for Nursing).



MILDRED E. SCHWIER

# Public Relations Guide

RITA MACISAAC

**M**UCH has been written and will continue to be written about the importance of sound human relations in our everyday activities. None of us can progress in our endeavors without the support and understanding of those with whom we live and work. People, those within our own profession and those beyond it, are essential to our progress.

With this in mind a Public Relations Guide has been prepared in both French and English by the Canadian Nurses' Association. It is based on the material originally suggested by the C.N.A.'s Public Relations Committee (1952-54) and has been completed during this biennium. To quote from the Foreword by Miss Gladys J. Sharpe, President of the C.N.A.:

It is the belief of the Canadian Nurses' Association that good public relations is primarily the sum total of building good will and understanding for our nursing profession in cities, towns and districts across the nation. As a consequence, this booklet is designed not only for the guidance of local chapters and provincial committees, but also for individual nurses interested in the progress of the nursing profession. The suggestions offered here can assist everyone in planning and executing a public relations program.

This month as nurses arrive at the Biennial Meeting in Winnipeg, each will find within her folder of reports a Public Relations Guide. From now on this booklet will be available from National Office and from provincial association offices at a nominal cost.

The material covers nine chapters and explains why we, as nurses, need public relations, discusses where we should start — namely, with ourselves — and moves on to describe external relations with the general public. A compact well-illustrated booklet, it is a

must for the professional and personal bookcase or library.

How many times do we attempt to put across a new idea or program, or to develop a project, only to meet with disappointment and failure? Could this be due to our method of communication? Did we take into consideration the interests of the people who had the power of developing or discarding our ideas and projects?

Other people do not see nursing as we see it, any more than we see a bridge as an engineer sees it, for example. People view nursing in terms of what it means to them and their immediate range of interests.

The appeal to a person's self-interest is the basis of sound communication and hence of public relations.

In order to be able to communicate effectively in the realm of nursing, one must know the facts about nursing. Thus public relations starts at home with ourselves, within our own organization. Each one of us, in an informal manner, is constantly interpreting nursing to the public. But what happens if nurses do not know the facts or are misinformed about the profession's objectives?

Impressions and opinions will be created which will discount any effort made by the profession as a whole to publicize nursing.

Where can nurses learn the facts? Where can they develop an understanding of the objectives of the profession? One answer is obvious — within the chapter and district professional organization. Active, interested chapters result in well informed nurses prepared to support our professional aims in all that they do or say.

Our professional organizations, to be effective, must depend on people to participate in their activities. These people, you and I, do not always contribute as much as we might to our association activities. Because of this natural human failing of indifference it is essential that interest be stimulated. It is not enough to complain about

Miss MacIsaac, who is assistant secretary of the Canadian Nurses' Association, is secretary of the Public Relations Committee.

small meetings and lukewarm attitudes, it is important to discover *why* these attitudes exist and *how* they may be changed.

Histories of hundreds of successful associations spell out the importance of good meetings. The program committee of a chapter, provincial or national organization is therefore an extremely important one.

The Guide provides suggestions for planning, promoting and producing meetings — always bearing in mind that to develop interested audiences, we must gear our topics and their presentation to the specific interests and work of each nurse. This is not as difficult as it may seem for basically, nurses' interests are similar — service to patients — it is only the way in which this service is rendered that differs. There is, no doubt, in all topics something that applies to each of us — if time were taken to make this evident. This is really the secret of good meetings.

The second step in a public relations program is to interpret our aims and objectives to as wide an audience as possible, be it in our immediate locality, our province, or our nation.

There are many ways of doing this through press, radio and television.

This is dealt with in detail in the booklet. Here, we are reminded that what may be geared to the interest of our own profession must now be interpreted in terms of a public who sees nursing as a hospital experience, a public health nurse, an occupational health nurse. What nursing is to the man in the street, the father, the employer or the elderly must be discovered and employed to gain support and understanding for this essential service. We have here a sympathetic audience but often an uninformed one.

Nursing is an essential service. We have a story to tell and a contribution to make. Each one has a part to play. The effort of one nurse to interpret her work to people outside the profession may seem like a drop in the bucket. But this effort, duplicated by 50,000 nurses, would reach virtually every Canadian and thereby develop a favorable, informed opinion about nursing.

These and other related topics are dealt with in the Public Relations Guide. The practical application of public relations techniques in nursing situations is here developed. The booklet is one which will be invaluable to all interested in public relations. By all, we mean every Canadian nurse for unity of effort is needed. "We may walk alone, but we never march alone."

## Provincial Association Activities

A review of the provincial reports as submitted to the CNA Executive Committee meeting in February, 1956 creates a general air of industry and accomplishment. There are still many problems requiring a solution but during the year 1955, the component associations appear to have attained important objectives, grown in professional solidarity and consequently have strengthened the parent association. Nationally, certain items have been of general interest or concern.

**Curriculum Study:** Five provinces are currently engaged in or have completed study and revision of existing minimum curricula. In Manitoba, all schools of nursing have started to re-

organize their programs in line with the revisions and it is hoped that either a partial or complete block system will be instituted in each by the end of 1956. Quebec hopes to have a first draft of the English revision ready very shortly and the French-language group are continuing work on their curriculum. Inclusion of psychiatric affiliation is a major concern in some provinces.

Approval of the National League for Nursing *test pool examinations* has recently been given by Manitoba, Prince Edward Island and Saskatchewan who thus join Alberta, British Columbia and Nova Scotia in using these papers. Ontario is currently con-



sidering possible use of them. Quebec is continuing a study begun previously of the results of the existing examination system and examination content. Manitoba, P.E.I. and Saskatchewan have discontinued first year qualifying examinations.

*Student nurses:* With one exception, all provinces reported considerable activity in this area. Newfoundland, Prince Edward Island and Saskatchewan were particularly diligent in student recruitment. P.E.I. conducted a survey to determine the respective effectiveness of the various recruitment techniques used — informal chats with students of nursing leading by a wide margin. Funds to assist students complete a basic nursing program are increasingly available — Manitoba and New Brunswick have recently established programs of assistance. The Ontario provincial association has undertaken to provide scholarships for students entering on a basic degree program. A branch of the Student Nurses' Association was recently formed in Nova Scotia making a total of four such provincial organizations.

*Civil defence:* This aspect of nursing is assuming growing importance in our basic program. Increasing numbers of nurses are benefitting from the course of instruction given at Civil Defence College, Arnprior. As they return to their respective fields they carry with them the responsibility of teaching their co-workers. In British Columbia each school of nursing is to have an instructor whose specific task will be to integrate civil defence methods and procedures into basic nursing study. The first institute of its kind since the inception of the school was held at the Provincial Civil Defence School in Fort Qu'Appelle, Sask. when discussion centred around the role of the nurse in civil disaster.

*Institutes and refresher courses:* Educationally, the year 1955 was varied, active and interesting. With few exceptions the provincial reports carry accounts of institutes, workshops and refresher courses covering many interest areas. The series of institutes in B.C. aimed to prepare a total of 225 "instructors" in body mechanics and rehabilitation nursing was, perhaps, the most unique. Ontario indicated good attendance at an institute

on growth and development conducted by the University of Toronto School of Nursing. Manitoba sponsored a series of institutes covering such subjects as administration, prenatal education, curriculum revision, geriatrics, and aseptic techniques. Other provinces concentrated on maternal health, mental health and pediatric affiliation programs.

In addition to these areas of similarity each province reported other developments peculiar to their individual situations:

#### ALBERTA

1. Instituted a survey of provincial office administration under the direction of Miss E. Stuart, professor of administration, University of Toronto.
2. Appointed a Task Committee to prepare a guide for an extensive survey of nursing and nursing education within the province.
3. Approved a recommendation to request the Department of Health to establish a program of training for nursing orderlies comparable to that now given to certified nursing aides.
4. Prepared a curriculum for psychiatric nurses.
5. Added a new chapter bringing the total to twenty-five.

#### NEW BRUNSWICK

1. With the assistance of Miss E. Kathleen Russell, undertook the task of studying ways and means to reorganize nursing education to provide more adequate nursing service.
2. Continued study of legislation for the auxiliary worker. This project and others hinge on the completion of the survey now underway.
3. Appointed a special committee to study private nursing registries and to draw up policies leading to more uniform standards and regulations.

#### NEWFOUNDLAND

1. Approved a new program of nurse education for one of its schools of nursing consisting of two years theory and practice and one year nurse internship. This program has also been implemented in another school on an experimental basis.

2. Prepared a report on the "Philosophy and Aims of Nursing Education" at the request of the National Committee.

3. Began the work of revising association bylaws and formulation of an outline of personnel policies.

4. Established committees in three schools of nursing to study and evaluate the "Head Nurse" study in its relationship to the functions of a head nurse in a small hospital.

#### NOVA SCOTIA

1. Set about the task of drawing up criteria to be used by the Executive Committee in evaluating schools of nursing.

2. Authorized the presentation of a submission to the Department of Health requesting restoration of Federal-Provincial Grants for increased residence facilities for nurses.

3. Completed arrangements for student affiliation in tuberculosis in the Cape Breton area.

#### ONTARIO

1. Instituted a study of provincial office organization.

2. Completed final arrangements for the construction of an office building.

3. Planned for a conference on evaluation in the basic nursing program with

specific consideration of the possible use of the N.L.N. testpool examinations.

#### PRINCE EDWARD ISLAND

1. Began construction of a provincial curriculum.

2. Recommended development of a program of psychiatric affiliation for students at the provincial psychiatric hospital.

#### QUEBEC

1. Established a fund to assist needy nurses.

2. Furthered the cause of public relations by agreeing to assist the CBC prepare two television programs that were televised last winter. They dealt with pertinent questions.

3. Considered the problem of an organized program of activities for visitors from other countries.

#### SASKATCHEWAN

1. Revised the act to include certification of nursing assistants.

2. Planned to bring a bill before the next session of the Legislature which would make the Centralized Lecture Program a part of the general nursing education structure. The official title of the program is to be "Centralized Teaching Program for Nursing Students in Saskatchewan."

An advanced training and research program in heart disease nursing is being developed by the Division of Nursing Education of Teachers College, Columbia University, with a recent grant from the National Heart Institute of the United States Department of Health, Education and Welfare.

In announcing the project, Prof. R. Louise McManus, division director, said "we believe that nursing problems of patients with heart disease should have high priority for special study at this time. Nurses have much to contribute to the prevention of the disease — the nation's No. 1 health problem — and to care for the acutely ill."

The project is an outgrowth of three years of TC experimentation in cooperation with the institute. It represents the first attempt at developing heart disease nursing

into a major clinical nursing field for graduate study.

Among the objectives of the project are to offer advanced training to experienced graduate nurses preparing for careers as teachers, supervisors, administrators, and consultants in heart disease nursing; to devise better ways to add instruction in heart disease nursing to basic general nursing courses; to show future faculty members how to develop this kind of nursing into their institutions' programs, and to make more widely known the growing knowledge of heart disease nursing.

The greatest barrier to the rapid development of heart disease control programs in nursing is the short supply of nurses with specialized knowledge of this field who can, in turn, train and supervise other nurses for such work, Mrs. McManus declared.

# NURSING EDUCATION

## Accreditation — What's on the Record?

FRANCES U. MCQUARRIE, B.A. Sc.

**Question** — How long has the CNA been discussing the possibility of establishing a program of accreditation for Canadian schools of nursing?

**Answer** — Since 1944. At the general meeting held in Winnipeg that year a panel of members recommended accreditation as one means of assisting schools of nursing to obtain their objective of preparing nurses to meet the needs of the Canadian people.

**Question** — Was any action taken on this recommendation?

**Answer** — Yes. In 1945 the CNA Executive Committee approved the principle of accreditation and asked the Committee on Nursing Education to initiate a plan of action as quickly as possible. But, we regret to say, at the general meeting in 1946 it was felt that, as funds were limited and other projects seemed to be more urgent, further action in regard to accrediting schools of nursing could not be taken at that time.

**Question** — Did this discourage future activity?

**Answer** — Definitely not! The CNA Committee on Nursing Education, convinced of the need for such a program, was instrumental in securing, in 1948, the appointment of the "Provisional Committee on Evaluation of Schools of Nursing."

**Question** — Has any nursing group ever attempted to evaluate or accredit schools of nursing in Canada?

**Answer** — The Canadian Conference of Catholic Schools of Nursing, starting in 1946, made an intensive

study of evaluation methods and carried out a field evaluation survey in selected schools of nursing.

**Question** — Was this study of value to the CNA?

**Answer** — Information was made available to the CNA Provisional Committee on Evaluation of Schools of Nursing which recommended that the CNA might be well advised to pursue a similar course. Once again, however, the recommendations were tabled because funds were not available. During 1950-52 no direct action was taken but various means were used to inform the membership about accreditation. A workshop at the 1950 Biennial meeting dealt with this subject and a series of articles appeared in *The Canadian Nurse*. Although the 1952 general meeting reendorsed the principle of accreditation, the subject remained dormant until 1955.

**Question** — What happened in 1955 that reawakened interest?

**Answer** — It was the unanimous opinion of the CNA Committee on Nursing Education, now having members from all ten provinces under the revised Bylaws of 1954, that some way must be found to make a start, at least, on a program of accreditation. At a full meeting in January 1955 it appointed a Task Committee to study ways and means of implementing a program of evaluation and accreditation. Under the chairmanship of Sister Denise Lefebvre, this Task Committee studied the principles and procedures of accreditation as applied elsewhere by the nursing profession and by other professional groups. From this study the Task Committee prepared a series of recommendations which were ac-

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Miss McQuarrie is nursing education secretary of the Canadian Nurses' Association.



cepted by both the Committee on Nursing Education and the Executive Committee earlier this year.

**Question** — What is the next step?

**Answer** — What is done from now on is up to the CNA membership. The Committee on Nursing Education, through its chairman, will report fully

on progress to date at the 28th Biennial Meeting in Winnipeg. It will ask every member to give consideration, once again, to ways in which our twelve-year-old hope can become a reality. Your understanding, interest and enthusiasm is necessary if we are to undertake a program of accreditation.

## L'Accréditation — Où en sommes - nous?

FRANCES U. MCQUARRIE

**Question** — Depuis combien de temps l'A.I.C. envisage-t-elle la possibilité d'établir un programme d'accréditation pour les écoles d'infirmières au Canada?

**Réponse** — Depuis 1944. Lors de l'assemblée générale de Winnipeg cette année-là, un groupe de membres constitué en jury se prononça en faveur de l'accréditation comme un moyen d'appuyer les écoles d'infirmières dans leurs efforts pour former des infirmières capable de satisfaire les besoins de la population canadienne.

**Question** — Une ligne de conduite quelconque a-t-elle été adoptée à la suite de cette recommandation?

**Réponse** — Qui. En 1945 le Comité Exécutif de l'A.I.C. a approuvé le principe de l'accréditation et a chargé le Comité de l'Education en Nursing d'établir un plan d'action aussitôt que possible. Malheureusement, en 1946, lors de l'assemblée générale on estima qu'il était impossible de poursuivre cette initiative vu qu'à cette époque les fonds disponibles étaient restreints et que d'autres projets semblaient plus pressants.

**Question** — Cette mesure eut-elle pour résultat de décourager toute activité future?

**Réponse** — Non pas! Le Comité de l'Education en Nursing de l'A.I.C., convaincu de la nécessité d'un tel programme, contribua en 1948 à la formation du "Comité provisoire d'Evaluation des Ecoles d'Infirmières."

**Question** — Y a-t-il jamais eu d'efforts tentés par une groupe quelconque d'infirmières pour évaluer ou accréditer les écoles d'infirmières au Canada?

**Réponse** — En 1946 la Conférence canadienne des Ecoles catholiques d'Infirmières fut une étude très serrée des méthodes d'évaluation et poursuivit une enquête auprès de

diverses écoles choisies dans ce but.

**Question** — Cette étude a-t-elle été utile à l'A.I.C.?

**Réponse** — Le "Comité provisoire d'Evaluation des Ecoles d'Infirmières de l'A.I.C. fut mis au courant de ces travaux et il exprima l'avis que l'A.I.C. devrait tenter une expérience analogue. Cependant, ici encore, les recommandations furent ajournées faute de fonds. Aucune action directe ne fut prise au cours des années 1950-52 mais différents moyens furent employés pour renseigner les membres sur la question de l'accréditation. Le sujet fut repris par une groupe d'études lors de l'Assemblée biennale de 1950 et une série d'articles fut publiée dans la revue *l'Infirmière canadienne*. Enfin, malgré l'approbation du principe de l'accréditation renouvelée en 1952 par l'assemblée générale, le sujet resta dans l'ombre jusqu'en 1955.

**Question** — Qu'est-ce donc, en 1955, qui ressuscita cette vieille question?

**Réponse** — C'est que le Comité de l'Education en Nursing de l'A.I.C. — désormais composé de représentantes des dix provinces en vertu des règlements révisés de 1954 — exprima l'opinion unanime qu'il fallait trouver un moyen de mettre en branle *au moins* un programme d'accréditation. En janvier 1955, le Comité se réunit au complet et forma une commission spéciale pour étudier les voies et moyens de mettre en oeuvre un programme d'évaluation et d'accréditation. Sous la présidence de Soeur Denise Lefebvre, cette commission étudia les principes et les procédures de l'accréditation tels que pratiqués ailleurs par la profession du nursing et par d'autres groupements professionnels. Cette étude permit à la commission de rédiger une série de recommandations qui furent acceptées au début de cette année par le Comité de l'Education en Nursing et par le Comité Exécutif.

**Question** — Que reste-t-il à faire?

Mlle McQuarrie est Secrétaire de l'Education en Nursing de l'A.I.C.

**Réponse** — C'est aux membres de l'A.I.C. d'en décider. A la 28ième Assemblée bien-nale le Comité de l'Education en Nursing, par l'intermédiaire de sa présidente, soumettra un rapport complet des progrès accomplis à ce jour. Il demandera à chaque membre

d'examiner encore une fois les moyens de réaliser cet espoir qui date déjà de douze longues années. Votre compréhension, votre intérêt et votre enthousiasme sont indispensables si nous voulons entreprendre un programme d'accréditation.

# Expérimentation dans le Domaine de l'Education de l'Infirmière

SOEUR ANNETTE DION, s.g.m.

**P**OUR LA PREMIÈRE FOIS, le 26 janvier 1954, l'Ecole d'infirmières de l'Hôpital Maisonneuve ouvre ses portes à quarante-cinq aspirantes, désireuses de réaliser leur généreuse vocation. Depuis cette date, l'école a reçu cent seize autres candidates soumises à un programme expérimental approuvé par l'Association des Infirmières de la Province de Québec et l'Université de Montréal. En différents milieux, on se plaint du manque d'infirmières, quoique les statistiques s'accordent à démontrer que le nombre de diplômées va toujours en augmentant. On attribuerait cette pénurie aux raisons suivantes :

d'être. Quant à l'expérimentation, rien ne s'y prête mieux qu'une institution nouvelle n'ayant aucune tradition à briser mais tout à construire. Ce n'est d'ailleurs pas la première tentative du genre au Canada si l'on juge par l'Hôpital Métropolitain de Windsor, Ont. et le Toronto Western. Les Etats-Unis aussi réalisèrent en ces dernières années de semblables expériences dans les hôpitaux du Massachusetts, Ohio, Michigan et New York. C'est cependant la première fois qu'un programme expérimental du genre est mis en exécution dans un hôpital catholique Canadien-français.

1. Expansion marquée dans le domaine de la santé en général, du nursing en particulier, des services sociaux et industriels; donc, champs d'action plus nombreux pour l'infirmière.

2. Nombre croissant de patients dans les hôpitaux, grâce aux assurances-groupes et l'amélioration des facilités cliniques hospitalières.

3. Construction et agrandissement des hôpitaux.

Dans le tourbillon de la vie au XXe siècle, l'infirmière moderne se voit confier des responsabilités antérieurement réservées au médecin. L'extraordinaire évolution de la science médicale exige un nursing plus complexe et plus scientifique par le fait même un plus grand nombre d'infirmières bien préparées; l'école d'infirmières de l'Hôpital Maisonneuve a donc sa raison

## BUT GÉNÉRAL

Préparer des infirmières compétentes pour aider les hôpitaux généraux, sanatoriums et autres services sanitaires de la province en vue d'assurer au malade le maximum de sécurité.

## BUTS PARTICULIERS

1. Assurer par une surveillance adéquate une solide formation clinique aux étudiantes-infirmières.

2. Adapter le mieux possible, le programme d'études au nursing.

3. Insister fortement afin de développer chez l'étudiante le sens des responsabilités.

## MOYEN GÉNÉRAL

Réduire à deux ans la période destinée au cours de base et réserver la troisième année à la préparation im-

Soeur Dion est la directrice à l'Hôpital Maisonneuve à Montréal.

médiate de l'étudiante à ses fonctions futures.

#### MOYENS PARTICULIERS

1. *Assurer une surveillance adéquate des étudiantes au cours de leur expérience clinique.* A l'aide de monitrices en nombre suffisant, guider constamment les étudiantes dans leur pratique auprès des malades surtout durant les deux premières années.

L'hospitalière assume actuellement toute la responsabilité de cette surveillance mais il est évident que sa tâche d'administration est trop vaste pour lui permettre de s'y dévouer autant qu'elle le désire. Le fait que l'autorité de l'hospitalière en matière de surveillance soit déléguée à des personnes préparées sans lui enlever la responsabilité lui permet de consacrer plus de temps aux problèmes administratifs. Constamment, l'étudiante doit appliquer ses connaissances théoriques à chaque malade en particulier . . . Institutrice autant qu'élève ont besoin de temps et de réflexion.

On constate souvent que le lien n'est pas assez intime entre la théorie et la pratique. Pour obtenir une meilleure corrélation, n'est-il pas nécessaire de guider sans cesse l'étudiante dans son travail auprès des malades?

Pour réaliser ce premier but, nous proposons une monitrice clinique pour quatre ou cinq étudiantes en moyenne, tenant compte que les débutantes nécessitent une surveillance à peu près constante. Les monitrices travaillent auprès des malades avec les étudiantes et leur enseignent à organiser leur activités de façon à ménager leur temps et leur énergie. Elles profitent de toutes les occasions de former leur jugement et de leur faire acquérir ou perfectionner les qualités constituant l'esprit de la profession. Ces monitrices ont le double rôle d'aider les étudiantes-infirmières et de surveiller les aides qui leur sont confiées assurant ainsi la sécurité du malade.

2. *Adapter le mieux possible le programme d'études au nursing en éliminant les notions qui ne sont pas purement de ce domaine.*

L'infirmière a son rôle propre, celui d'auxiliaire du médecin. Il est de la plus haute importance que ces cours soient orientés vers les connaissances qui lui permettront de demeurer dans son champ d'action, le nursing. Pour réaliser ce deuxième but nous avons:

a. Procédé à une analyse complète du contenu des matières du programme, en particulier les sciences de base.

b. Éliminé les données purement théoriques ne trouvant pas leur application dans la pratique du nursing.

c. Remplacé ces notions par des cours plus élaborés de psychologie, hygiène mentale et sociologie pour mieux comprendre la nature humaine et les différences individuelles des malades.

3. *Utiliser des moyens propres à développer chez l'étudiante le sens des responsabilités en la préparant à ses fonctions futures.*

On ne saurait trop insister sur l'importance de cette qualité chez l'infirmière, puisque des vies humaines sont entre ses mains. Le fait d'être chargée de certaines responsabilités positives ne serait-il pas favorable à ce développement?

Pour réaliser ce troisième but, le programme clinique est organisé de façon à laisser à l'étudiante, au cours de la troisième année, le soin de travailler comme chef d'équipe et de surveiller quelques élèves moins avancées. Vers la fin de cette dernière année, on permettra à l'élève de suivre des cours de surveillance hospitalière et d'enseignement clinique; elle sera également admise à collaborer avec l'hospitalière dans son travail de surveillance générale du département.

Nous espérons donner une idée du programme expérimental. Notre but comme celui de toute infirmière étant le bien du malade, nous espérons par cette nouvelle méthode d'éducation, continuer d'aider nos frères souffrants.

German investigators claim to have found a reliable and effective oral substitute for insulin. Present reports are being viewed with caution by physicians in view of previous failures. In older patients (over 40)

with a diabetic history of less than 10 years and a period of insulin therapy under one year, the drug produced remarkable therapeutic results in a high percentage of cases.

— *Scope Weekly*



# NURSING SERVICE

## Orientation

F. LILLIAN CAMPION

THE ORIENTATION MANUAL prepared by the Canadian Nurses' Association will be available in June. It was prepared by the Committee on Institutional Nursing, 1952-1954 biennium and the Committee on Nursing Service, 1954-1956 biennium.

The manual is offered as a guide only. It is recognized that an orientation program will vary with the size and complexity of the organization. Each agency must plan a program that will meet its own needs and that can be adapted to meet the needs of individual employees.

### WHY ORIENTATION?

An individual's adjustment to a new job is frequently a disturbing experience. With the increasing complexity and variations of our modern health agencies, a nurse is required to make many adaptations of her basic skills and knowledge in each new situation in which she finds herself.

The more help a person receives in making these adaptations, the more quickly she is able to function at her maximum efficiency. The greater her understanding of the over-all objectives of the agency, and of her part in the total effort, the greater will be her cooperation. The sooner she learns the techniques, policies and procedures approved by the agency, the sooner will she be able to use her own initiative in meeting the needs of those whom she serves. The fewer the frustrations she encounters, the greater the satisfaction she will have in her work and

the higher the quality of service she will render.

A well-planned orientation program is essential in assisting the new nurse to gain the required knowledge and understanding and to make the necessary adaptations that will enable her to give a high quality of service with consequent personal satisfaction.

### WHO BENEFITS?

#### 1. *The individuals served by the agency:*

Whether it is the patient in the hospital, the family in the community or the worker in industry, all will benefit by receiving a higher quality of service from a worker who knows her responsibilities and duties, who is in harmony with the aims and objectives of the agency, and who feels secure in her work.

The safety of the patient is assured when an employee is made aware of possible hazards. Accidents, which may occur when a worker is uninformed, are prevented. Lives may be saved when the worker knows the equipment and measures to be used in meeting emergency situations.

#### 2. *The employing agency:*

A well-planned orientation program is an economy measure for the employing agency. The new employee is helped to avoid mistakes which can be very costly in terms of patient safety, wastage of time and misuse of expensive equipment.

The professional skills of the nurse are utilized at a maximum level more quickly. Greater unity and cooperation between all workers is established and morale is raised. A satisfied staff results in a reduced turnover which

Miss Campion is secretary of Nursing Service in the Canadian Nurses' Association.

means a more economical operation of the agency.

There is no better way for a health agency to establish good public relations than by giving a high quality of service through a happy and able staff.

### 3. *The employee:*

The employee benefits by avoiding the feeling of ineptitude, anxiety and frustration which results from lack of knowledge and understanding as she enters a new situation. She attains a feeling of security and personal satisfaction through the knowledge that she is giving a high quality of service.

### THE ORIENTATION PROGRAM

There are certain essentials which

should be included in any program of orientation. In addition, there are specific items that relate to a particular field of nursing and others pertaining to the individual agency within that field. The manual includes the general content of an orientation program and methods which may be used. It outlines suggestions for a program in each of three major fields — hospital nursing, generalized public health nursing and occupational health nursing. A bibliography and samples of an application form and an evaluation form are appended.

The manual on orientation may be obtained from the Canadian Nurses' Association, 270 Laurier Avenue West, Ottawa, Ontario, or your provincial nurses' association at a nominal cost.

## Rheumatoid Arthritis

RITA ZIEHRAN

**R**HEUMATOID ARTHRITIS is an inflammatory condition of the joints that usually produces considerable stiffness and pain in the affected areas. It is a chronic disease that involves the white fibrous tissue. The cause is unknown. It has been variously attributed to some virus, to endocrine gland irregularity, to stress or worry.

Quite often persons with rheumatoid arthritis appear rundown and tired as well as being great worriers. Many have been hard workers who have had little time for relaxation. They may give a history of loss of appetite, weight loss and general debility. They give an appearance of being chronically ill.

The earliest symptom frequently is stiffness and soreness in the fingers when these patients waken in the morning. As the condition progresses other joints are affected, with severe pain being experienced when the weight-bearing joints become involved.

Miss Ziehran is a senior student at the University of Alberta Hospital, Edmonton. She won the second prize in the contest sponsored by the Macmillan Company of Canada Ltd.

There may be a low-grade fever. Usually, there are periods of improved health followed by repeated attacks with eventual, more or less permanent crippling. Objective symptoms may include:

1. *Joints:* Stage I. Increased periarticular tissue, increased joint fluid, local redness and heat.  
Stage II. As the inflammatory process heals, scar tissue forms which restricts joint movement.  
Stage III. Cartilage erosion, adhesions, joint fixation.  
Stage IV. Joints hopelessly fused, deformed, or even dislocated.

Joint crepitus is common. Unlike degenerative arthritis limitation of motion is due to bony ankylosis rather than bony deformity.

When deformity of the hands occurs, the distal phalanges are hyperextended and the proximal ones are flexed with a resulting ulnar deflection of the fingers. The skin covering the fingertips is thin, pale, smooth and shiny. The nails are rough and brittle.

2. *Muscles:* Because of joint flexion, muscle spasm and acute inflammation

frequently occur. There is a risk of disuse atrophy because of the neuralgic type of pain associated with movement.

3. *Sedimentation rate* is usually elevated over 30. This is an index of the tissue destruction and chronic inflammation.

4. *Systemic symptoms*: Decrease in subcutaneous fat. There may be a degree of anemia as well as evidence of vitamin deficiency. Splenic enlargement or pleural effusion may occur.

Complete rest, mental as well as physical, *but not vegetation*, is essential in the treatment of rheumatoid arthritis. The diet should be high protein, high vitamin and adequate in calories to build these patients up to their optimum weight. Care must be taken, of course, that they do not continue to gain to the point that they are overweight since this puts an extra strain on the joints.

The subject of my study, Mrs. Ball, is a 52-year old woman who has had arthritis for the past 15 years. It started in her right shoulder and arm then progressed to her right knee which became very swollen and painful. Soon, it moved into her other knee and eventually all the smaller joints became involved also. She has been unable to walk around very much for many years because of the pain in her knees and ankles which were very swollen and tender when she was admitted. Movement was exceedingly restricted in both wrists and the right elbow could not be straightened beyond a 30° angle. Mrs. Ball's standing and walking posture were very poor. She had extreme difficulty getting up from a chair unless her head was pushed forward below the level of her knees. Somehow she had learned to balance herself in this position. As well as her arthritis Mrs. Ball was troubled with poor eyesight. When she came to the hospital she appeared to be quite depressed mentally.

X-rays revealed that her chest, heart and lungs were normal. The x-ray of her shoulders showed that there was an extensive marginal erosion of the articular surface of the upper end of the humerus. There was general osteoporosis, most marked in the peri-articular region.

The urinalysis report was within normal limits excepting for cloudiness

that was probably due to the presence of crystals and protein trace. The latter may indicate some renal damage. It was advised that Mrs. Ball should be given plenty of fluid to prevent renal calculi formation. The hematology picture indicated she was slightly anemic — 80%, 11.6 gm. The polymorphonuclear neutrophil count was slightly above normal — 71%. Her sedimentation rate was 36 mm./hr.

Mrs. Ball's appetite was not particularly good when she came to the hospital. To encourage her to eat she was given an "as desired" diet, carefully prepared and attractively served. Soon she was eating much more satisfactorily. An iron preparation and special vitamin capsules were given as well as adequate quantities of fruits and vegetables. Spices, condiments, concentrated sweets, fried foods and pastry were restricted.

Pain was alleviated by rubbing the joints with oil of wintergreen, the use of analgesics and sometimes hot water bottles. Acetylsalicylic acid with codeine grains half, two tablets every four hours, as needed, helped to ease the pain in the acute stage of the disease. Extreme care must be exercised in giving narcotics to arthritic patients and their use should be avoided as much as possible. Arthritis is a long-term illness and addiction may result from the casual use of narcotics. Sodium salicylate, gr. x q.i.d., was given as an analgesic and antipyretic. A constant watch must be kept for untoward reactions, in the administration of this drug. Such symptoms as ringing in the ears, dizziness, disturbances of hearing and vision, increased perspiration, nausea, vomiting, diarrhea and lowered prothrombin time, may occur.

Intramuscular injections of a new treatment — Lauron — were administered to Mrs. Ball. This is a gold preparation. It is believed to arrest the inflammatory process though it does not repair damaged bone or cartilage. Contraindications to its use are pregnancy and nephritis. Being a heavy metal, it could be extremely toxic. "B.A.L." is the preferred treatment for such metal poisoning. However, with Lauron most of the reactions are mild and transient, such as, dermatitis, albuminuria, soreness



of the mouth and agranulocytosis.

British Anti-Lewisite (2, 3 - dimer-captopropanol) has detoxifying properties for certain heavy metal poisonings. It was developed initially as an anti-gas warfare agent. It rapidly combines with the metal ion and effectively binds it *in vivo*, rendering it harmless until it is eliminated from the body. It is a viscous, oily liquid and is administered intramuscularly in a 10 per cent solution in peanut oil and benzyl benzoate. The usual dosage is 2.5 — 3 mg. per kilogram of body weight. The toxicity is transitory. For the more severe side effects of B.A.L. the barbiturates are a good antidote. It is effective for arsenic, bismuth, mercury and gold poisoning.

Tolerance to the gold injections is checked by a weekly urinalysis and a bi-weekly white blood count. Progress is shown by checking the sedimentation rate and the hemoglobin every three weeks.

#### PHYSIOTHERAPY

Physical medicine is the science dealing with the treatment of disease by physical agents such as light, heat, cold, water, electricity, massage, and mechanical agents. The principles of physical therapy applicable in the treatment of rheumatoid arthritis include:

Maintenance of maximum range of movement. Performance of full range movement slowly, once daily, will insure preservation of mobility. This should be done in the late morning or early afternoon before pain and fatigue set in. Before this treatment is started heat treatment and an analgesic are given. Pain produces muscle spasm which in turn produces more pain. The heat treatment reduces the spasm and the analgesic controls the pain.

Physiotherapy treatments are given only once a day to prevent stress and strain. All the possible movements of every affected joint should be taught, for example, in wrist exercise not only flexion and extension but also radial and ulnar deviation, pronation and supination must be included. The formation of joint adhesions will be prevented in this way.

Muscle building exercises are essential. To perform adequately and accurately

ly in fulfilling their function of joint movement responsive muscles under good voluntary control are necessary.

The correction of existing deformities and the prevention of new ones is a vital part of the physiotherapy program. Every effort is made to restore the joints to their most useful position. So far as possible weight-bearing joints are given a rest though they are not allowed to become inactive.

Physiotherapy had an important part to play in restoring Mrs. Ball to activity. On the ward she was encouraged to walk about with the aid of her crutches. Improved posture of all of her limbs was sought. To this end, sandbags were placed parallel to her knees at night to prevent outward rotation of her hips.

In the physiotherapy department she had steam baths each morning followed by massage. In the afternoons paraffin baths were provided for both hands. Very slowly but surely there was improvement. Her knees could be extended more, she suffered less pain, she became more cooperative, her posture was much better. After three months of hospitalization and physiotherapy Mrs. Ball was able to hand-operate a wheelchair.

#### NURSING CARE

Conscientious care, extreme gentleness and patience are essential in looking after arthritic sufferers. Getting them up out of bed is very essential. Mrs. Ball was placed in a chair frequently with her shoulders and elbows well supported by pillows. The periods were kept short at first as over-fatigue increases pain and discomfort even if strain is avoided.

Correct posturing in bed to prevent and improve deformities is of vital importance. Place the limbs so that the joints are in the most useful positions. Use a foot board to prevent footdrop and make sure that the feet are against the board. If the patient is very short, a butter box or block should be used to bring the support within reach of her feet. Never place a pillow under the knees since this tends to increase a flexion deformity. Pillows placed behind the lower half of the calves and heels helps the weight of the legs to straighten an existing

flexion deformity in the knees. Shift the legs off the pillows periodically to relieve posterior knee pain. External rotation of the hips is prevented by using sandbags. Flexion deformity of the hips is caused by lying supine too much of the time. Frequently place the patient in the prone position (face down with feet over the end of the mattress and resting against the foot board to prevent rotation of the feet and hips). When the patient is lying prone, keep the shoulders well padded. Always have a fracture board on the bed and a firm, non-sagging mattress.

Temperature, pulse and respirations should be recorded every four hours during the acute stage of the illness or as long as the temperature remains elevated.

Good routine nursing care should always be insisted upon including: skin and back care to prevent bedsores — adequate morning and afternoon care. Bony prominences should be rubbed with alcohol and kept well padded. A daily bath is refreshing especially if the patient can negotiate getting into and out of the tub. Good oral hygiene is essential. The patient should be assisted to comb and set her hair, to tie her shoe laces, to get her arms into a dressing-gown. Use care and gentleness whenever any of the painful joints have to be moved.

#### TEACHING AN ARTHRITIC

Though every school child is taught general health habits, it is frequently necessary to repeat them for older persons especially when they are ill. Mrs. Ball was instructed to wear her new glasses at all times for reading and to be sure she was in a good light. The correct bed postures to prevent deformities were demonstrated and emphasized. Information about arthritis was given. She was made to realize that recovery is a long-term proposition and not an overnight miracle. She was warned of the factors that might cause a recurrence of the acute stage: over-fatigue, infection in the nose and throat, insufficient rest, exposure to cold and dampness.

In preparation for her discharge from hospital, simple methods of applying heat at home were taught. The importance of maintaining good pos-

ture and having a firm, non-sagging mattress on her bed was stressed. Since she would be limited to her crutches or wheelchair, for the time being, she was instructed how to move around on or in each. The necessity of keeping her crutches in good repair, especially the rubber suction cups, was stressed. Living accommodation on the first floor of a new home was found for her so she could more readily get outside.

#### MENTAL STATE

Mrs. Ball was very bitter and depressed when she first came to hospital. Her husband had deserted her ten years previously. During all those years she had had no occupation, no hobbies, no home, no money. Being almost completely dependent on charitable organizations she felt neglected and had little desire to live. She was discouraged over her slow progress and frequently wept. She needed a great deal of encouragement and reassurance. Her spirits gradually improved in the cheerful and friendly atmosphere of the ward. Her bed was moved occasionally to overcome her irritability with other patients who wanted to listen to their radios.

Financial assistance from the Arthritic Clinic paid for the gold injections that started her on the road to a degree of recovery. The hospital's social worker located her sister who began to show Mrs. Ball small attentions and eventually offered her a place to live. Mrs. Ball enjoyed concerts and shows that were provided occasionally in the hospital auditorium. She became interested in sewing felt animals, thereby securing a hobby and an opportunity for much-needed exercise. All of these activities greatly improved her morale and speeded her recovery.

#### PROGNOSIS

The prognosis for patients with rheumatoid arthritis varies. Less than one-quarter recover completely; half of them can be greatly improved with treatment; the remainder become progressively worse. Most patients experience periodic flareups which usually subside gradually. A great majority

of cases can be helped to the extent of preventing major deformities.

It is well known that a patient's pain threshold varies with her personality. A pessimistic attitude, worry, a feeling of insecurity tend to increase pain; understanding, encouragement and reassurance help to reduce it. As Mrs. Ball's mental state improved, her response to the treatments and especially the physiotherapy released her from a great deal of her suffering.

#### POST-HOSPITAL CARE

Before she was discharged from the hospital arrangements were made with the public health nursing services in the community to anticipate her dif-

ficulties in adjustment, to provide the necessary home care and to continue the emotional reassurance she had been receiving. When she came to the hospital for physiotherapy she looked like a different person. Her posture was much improved. Her whole outlook on life had changed. She knew she was progressing and gradually she began to radiate a wholly new cheerfulness.

A tremendous sense of satisfaction and achievement results from nursing these patients and seeing our combined efforts yield a human being who can once again live a reasonably normal life and who faces the future without a desire to escape from reality, who is rid of the feeling of being unwanted.

## In Memoriam

**Eva Coleman**, a graduate of St. Joseph's Hospital, London, Ont., died at St. Thomas, Ont. on February 24, 1956 after a long illness. Miss Coleman nursed in London for several years.

\* \* \*

**Ann Elizabeth Delves**, who died at Winnipeg on March 2, 1956, at the age of 62, served as a nursing sister during World War I and worked at the Winnipeg Municipal Hospital during the polio epidemic.

\* \* \*

**Robena (Williams) Glass**, who was superintendent of the Charlotte Englehart Hospital, Petrolia, Ont., for 12 years, died there on February 29, 1956, after a lengthy illness. Mrs. Glass was a graduate of a Regina Hospital.

\* \* \*

**Bernice Good**, who graduated from Holy Cross Hospital, Calgary in 1923, died recently.

\* \* \*

**Vera (McMullin) Monan**, who graduated in 1930 from St. Michael's Hospital, Toronto, died in February, 1956. Mrs. Monan engaged in private nursing for some time then joined the staff of the Rehabilitation Hospital at Malton, Ont.

\* \* \*

**Ethel (Boulton) Rose**, A.R.R.C., who graduated from Vancouver General Hospital in 1913, died at Vancouver on March 5, 1956.

Mrs. Rose was decorated for her services overseas during World War I. On her return home, she engaged in social work at V.G.H. for some years.

\* \* \*

**Hattie May (Drake) Scott**, who graduated from Prince Edward Island Hospital, Charlottetown, in 1913, died in Oregon during January, 1956.

\* \* \*

**Estella (Beck) Townsend**, who graduated in 1927 from Holy Cross Hospital, Calgary, died in February, 1956. Following graduation, Mrs. Townsend worked at High River and Alsask.

\* \* \*

**Wanda (Hooper) Watson**, who graduated from St. Paul's Hospital, Vancouver, in 1921 died at Victoria on March 20, 1956, at the age of 58, after a long illness. Mrs. Watson retired in 1951, after serving as matron of Premier Mines Hospital for 15 years.

\* \* \*

**Ida Clara Welbourn**, who graduated from the Children's Hospital, Winnipeg, in 1919, died at her home near Peterborough, England, on January 25, 1956. Miss Welbourn engaged in staff nursing at the Children's Hospital, Los Angeles, for 24 years then served as the night supervisor until her retirement in April, 1955, when she went to England to live.



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The expanding requirements of our customers in the four Maritime Provinces, Quebec, Ontario, Manitoba and British Columbia as at present, will continue to be supplied entirely from our modern plant in Brockville, Ontario, from which all shipments to these areas will be promptly dispatched.

## **FARMER'S WIFE**

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# Nursing across the nation



prepared by your national office Canadian Nurses' Association, Ottawa

## *Civil Defence College, Arnprior*

Seventy-four nurses from across Canada participated in a week's course last March, bringing them up-to-date with the newer aspects of atomic warfare. For the most part representing schools of nursing, this group completed the series of courses designed to assist nursing educators in the teaching of civil defence nursing in the basic curriculum.

The impression left was, on the whole, one of optimism — that there is a possibility of evacuation being carried out — that it will be successful, provided we prepare now.

The best preparation is one of preparedness for *natural* disasters which may occur at any time anywhere in Canada. If a systematic, intelligent plan is developed now — whereby all existing facilities are put into action at a moment's notice — precious time and personnel will not be wasted in time of disaster.

That we as nurses will have a special role to play in disaster is evident, that this role will help us to adjust to difficult situations is consoling. That civil defence is merely an extension of existing community facilities makes one realize how a little advanced thinking and planning, real understanding and a desire to preserve our way of life will go far in developing a state of constant preparedness.

Nurses can do much, not only among their own groups, in promoting awareness of the prime need of today — to be prepared — but among all members of the community. Leadership in its strongest sense will be expected of the nurse in disaster — leadership is expected of her today — let us fulfill our obligation.

## *Public Relations in Action*

Tribute should here be paid to the

staff and lecturers at the Civil Defence College for their kindness to and interest in the welfare of visitors to the college. Over and over again the nurses were heard to comment on the helpfulness of all staff members. Truly, one's wish was their command.

One left this course with the feeling that those responsible for preparing Canadians to face possible mass disaster are firmly convinced of what they teach. The importance is transmitted to their students, developing in each a responsibility to support civil defence planning in each and every Canadian community.

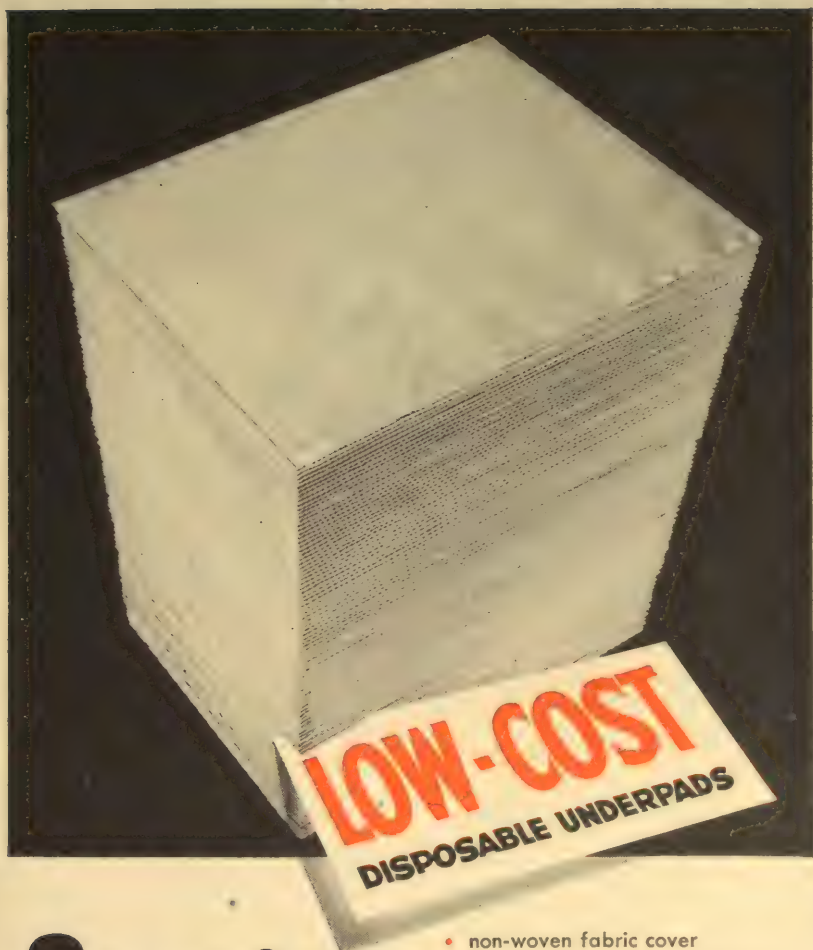
## *Keeping You Informed*

Have you ever wondered in between Biennial Meetings just what the Committee on Nursing Education was doing? We plan to keep you posted more frequently than in the past. From time to time the secretary of this national committee will be reporting on interesting projects under way, on what the committee feels on certain aspects of nursing education and what it plans to do in the future. We cannot start this month for the obvious reason that the Biennial is upon us, but watch for future articles.

## *What One University Women's Club is Doing*

National Office has been pleased to assist the "Status of Women" group of the Ottawa University Women's Club. Having read several recent press releases from the Canadian Nurses' Association stressing the need for more financial independence for schools of nursing by means of government support, this group has been closely examining the problem.

They have come to us for information about the amount of money now being given to basic nursing education,



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the pros and cons of making schools of nursing more independent of the service needs of hospitals, and how public money could actually be used for this latter purpose. They feel that this is a project which could be taken up effectively by other clubs across Canada because nursing education must be dealt with provincially. What an asset it would be to nursing to have a powerful group of women in each province working with us towards making nursing education truly educational!

### *Professional Training Grants*

In preparation for a Dominion-Provincial conference, the Department of National Health and Welfare made a summary of Professional Training Grants given under the National Health Program from 1948 to 1955. The grand total of health personnel trained under all grants from May 1, 1948 to March 31, 1955, was 9,350. Of this group 3,772 were registered nurses who received postbasic training as follows:

Public Health Nursing	1,293
Teaching and Supervision	809
Psychiatric Nursing	261
Pediatric Nursing	24
Staff (through short courses)	1,171
Others (Institutes, etc.)	293
	<hr/>
	3,851 (courses)

In addition, 1,263 nursing assistants were trained.

These bursaries are allotted and administered by the provinces, but financed by the Federal Government. In most cases the only condition attached to the bursary is that the recipients return to their own province and give at least one year's service for each year of study.

### *Some Recent Readings*

Hospitals are becoming increasingly aware of the need for an in-service education program as a means of improving service by stimulating the interest and growth of the worker. Two items of interest to those concerned with the development of in-service education have been received in National Office recently. One is a

report of "A Hospital In-Service Educational Training Program" which was developed by the Educational Department of the hospital with the aid of the Community Services in Adult Education.<sup>1</sup>

The report describes the development of this program, gives an evaluation and offers helpful suggestions to those interested in a similar undertaking.

The second item is "Hospital Adult Education" — a handbook prepared by the writer of the above report.<sup>2</sup> The handbook presents a "step-by-step guide to aid in developing and accomplishing a type of hospital in-service program which has, to a large extent, succeeded."

All nurses concerned with total and continuing nursing care will be interested in a book titled "Hospital and Community."<sup>3</sup> This is a report of a study of an unselected group of male patients treated in acute medical units of four hospitals in Scotland. The study considered the circumstances of their illness, the results of the treatment, and how the patients fared after they left the hospital. In the preface, the authors state:

Within the limitations imposed by the severity of an illness, the permanence of benefit derived from hospital treatment depends largely on the nature of conditions at home and at work, to which the patient returns on leaving hospital. It seems clear that further breakdown is sometimes precipitated by the transition — often sudden and dramatic — from the protective care of the modern medical ward to spartan conditions outside. Hospital treatment is usually only an episode in the general care of the patient; and the health services cannot stand in isolation from other social services.

1 "A Hospital In-Service Educational Program" — a report of the program at Veterans Administration Hospital of Indianapolis, October 1952 to June 1953. Observed and Reported by Russell E. Vance, Jr., field consultant and instructor in adult education and published by the Community Services in Adult Education, 1804 East Tenth Street, Bloomington, Indiana.

2 "Hospital Adult Education" by Russell E. Vance, Jr., and published

**KNOX**

## Protein Previews



### New Study Shows Gelatine Restores Brittle Fingernails to Normal



Brittle, fragile or laminating fingernails are the bane of many a woman's existence. Now, you can help these patients attain substantial relief in a large percentage of cases.

In a recent study<sup>1</sup> that confirmed previous work<sup>2</sup> Knox Gelatine was used to treat 36 women with fragile, brittle, laminating fingernails. Except for three patients who discontinued the therapy, three diabetics, and two women who had congenital deformities, the splitting ceased and all other patients were able to manicure their nails to a full point by the time the study ended.

Optimal dosage proved to be one envelope (7 grams) of Knox Gelatine ad-

ministered daily for three months. Improvement, however, was noted after the first month.

1. Rosenberg, S. and Oster, K. A., "Gelatine in the Treatment of Brittle Nails," *Conn. State Med. J.* **19**: 171-179, March 1955.

2. Tyson, T. L., *J. Invest. Dermat.* **14**: 323, May 1950.

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by the Community Services in Adult Education.

- 3 "Hospital and Community" by T. Ferguson, professor of public health, University of Glasgow, and A. N. MacPhail, lecturer in public health, University of Glasgow, published for the Nuffield Provincial Hospitals Trust by Geoffrey Cumberlege, Oxford University Press.

### *"I Am A Nurse"*

We were privileged recently, during the visit of Miss Mavis Avery, general secretary, Royal Australian Nursing Federation, to view the Australian nursing film "I Am A Nurse." Running for eleven minutes, this film prepared four years ago portrays in a very simple and meaningful manner the experiences of a student nurse. Designed as a recruitment film and prepared by one of the state governments, it has had wide distribution throughout Australia.

Another film is now being planned

by that government which will deal with the opportunities open to nurses upon graduation.

### *Packing Your Bags?*

By now, many of you will be doing some last minute shopping, dusting off your bags and preparing to pack up for your trip to Winnipeg and the 28th Biennial Meeting.

Much thought and planning has gone on in an effort to make this meeting a truly professional experience. Speakers have been invited from various fields so that the best thought and knowledge may be drawn upon as nursing considers its responsibilities in serving our nation.

An active and truly ingenious Arrangements Committee in Manitoba, working with our co-hostesses in Saskatchewan, has planned diligently to make our visit to Winnipeg a memorable one.

*Bon Voyage* to all who are convention-bound and we'll be seeing you!

## *Le Nursing à travers le pays*

### *Collège de la Défense civile d'Arnprior*

Soixante-quatorze infirmières venues de toutes les parties du Canada participèrent, en mars dernier, à un cours d'une semaine sur les aspects de la guerre atomique. La plupart des participantes étaient des institutrices venues compléter les cours déjà reçus afin d'être en mesure d'introduire le nursing de la défense civile dans le programme du cours de base.

L'impression générale en fut une d'optimisme — l'évacuation d'un grand nombre de personnes peut se faire avec succès, pourvu que nous nous y préparions dès maintenant.

La meilleure préparation consiste à être toujours en état de faire face aux désastres naturels qui pourraient survenir en tout temps et n'importe où, au Canada. Si l'on élabore un plan systématique au moyen duquel toutes les ressources peuvent être mises en disponibilité à un moment d'avis, il en résultera un emploi judicieux du personnel et du temps, éléments précieux en cas de désastre.

De toute évidence, les infirmières auront un rôle spécial à jouer en cas de désastre, rôle dont l'importance est incontestable. La défense civile n'est en somme que l'extension des ressources qu'offre la communauté; un peu de prévoyance, des plans arrêtés à l'avance, un désir véritable de conserver ce que nous avons, sont suffisants pour nous inculquer le désir de nous tenir dans un état constant de préparation.

Les infirmières peuvent faire beaucoup pour convaincre non seulement leurs compagnes mais tous les membres de la société de la nécessité d'être prêts, en tout temps. Les infirmières, en cas de désastre, seront des chefs dans le vrai sens du mot; aujourd'hui on a besoin d'elles comme guides; efforçons-nous de remplir nos obligations.

### *Les relations extérieures à l'oeuvre*

La bonté et l'intérêt manifestés par le personnel et les conférenciers du Collège de la Défense civile à l'égard des visiteurs du collège méritent d'être mentionnés. A maintes reprises l'on a entendu de la part des

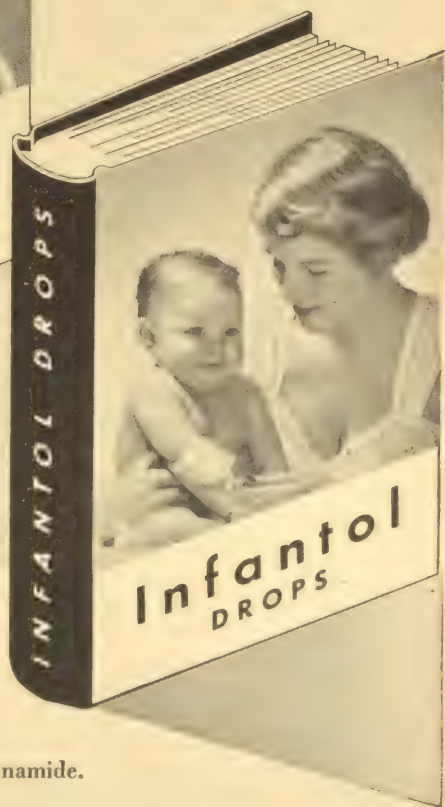


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infirmières des remarques très obligeantes sur la collaboration bienveillante de tous les membres du personnel. Vraiment, nos désirs étaient des ordres.

En quittant le collège, à la fin du cours, chacune avait l'impression que ceux qui ont la charge de préparer les Canadiens en cas de désastre sont absolument convaincus de l'utilité de leur enseignement. Cette conviction est communiquée à leurs élèves, inculquant à chacune un sens de responsabilité envers la défense civile et le désir de collaborer à son organisation où que ce soit au Canada.

#### *Pour vous renseigner*

Vous êtes-vous déjà demandé ce que fait le Comité de l'Éducation en Nursing en dehors du Congrès biennal? Nous nous proposons de vous renseigner, à ce sujet, plus souvent qu'autrefois. La secrétaire de ce comité national fera, de temps à autres, un rapport sur les projets en cours, sur l'opinion du Comité concernant tel ou tel aspect de l'éducation en nursing ou sur les projets futurs. Ce mois-ci, il est impossible de vous en dire davantage parce que déjà il faut nous occuper du Congrès Biennal, mais, surveillez les articles à venir.

#### *Ce qu'a fait le "University Women's Club," d'Ottawa*

Le secrétariat national a été heureux de renseigner un groupe de "l'University Women's Club" qui s'intéresse particulièrement au "Statut de la Femme." Ayant lu dans les journaux plusieurs communiqués publiés par l'Association des Infirmières Canadiennes sur la nécessité d'une plus grande indépendance financière pour les écoles d'infirmières, et sur l'aide indispensable des gouvernements pour arriver à cette fin, ce club de femmes s'intéressa vivement à ce problème qu'il étudia très attentivement.

L'on nous demanda des informations sur les argents actuellement versés pour l'enseignement de base donné par les écoles d'infirmières, sur les points en faveur et contre une plus grande indépendance pour les écoles d'infirmières et sur la façon dont les deniers publics pourraient être utilisés à cette fin. Les membres de ce club croient que cette question pourrait être étudiée par d'autres groupes à travers le pays parce que la question d'éducation des infirmières est du domaine provincial. Quel avantage ce serait pour la profession d'infirmière si un groupe important de femmes, dans chaque province,

travaillait avec nous, à faire de la formation des infirmières une véritable question d'éducation!

#### *Octrois pour la formation professionnelle*

En vue de la conférence fédérale-provinciale, le Ministère de la Santé et du Bien-Être national a fait un relevé des bourses d'études accordées en vue de la formation professionnelle, de 1948 à 1955. Le nombre total de personnes ayant bénéficié de ces octrois a été de 9,350, du 1 mai 1948 au 1 mars 1955. De ce nombre, 3,772 infirmières ont suivi des cours post-scolaires; en voici le détail:

Hygiène publique	1293
Enseignement et surveillance	809
Psychiatrie	261
Pédiatrie	24
Divers (de courtes durées donnés au personnel)	1171
Autres (conférences, etc.)	293
	<hr/>
	3851 (cours)

En plus, 1,263 auxiliaires en nursing furent formées.

Ces bourses sont accordées et administrées par les provinces mais financées par le gouvernement fédéral. Dans la majorité des cas, la bourse est accordée à la seule condition que l'infirmière revienne dans sa province pour y faire une année de service, une fois ses études de perfectionnement terminées.

#### *Nous avons lu récemment...*

Les hôpitaux se rendent de plus en plus compte de la nécessité d'un programme d'éducation en cours d'emploi, en faveur de leur personnel, comme moyen d'améliorer le service, en stimulant l'intérêt et en élargissant le champ des connaissances de l'infirmière. Nous avons reçu dernièrement au secrétariat le rapport du programme d'éducation, en cours d'emploi, du personnel d'un hôpital; ce rapport fut préparé conjointement par le département de l'éducation de l'hôpital et la société d'éducation des adultes de la localité. Le rapport contient des suggestions intéressantes.

Nous avons aussi reçu "L'Éducation des adultes à l'Hôpital," manuel préparé par l'auteur du rapport déjà cité. Ce manuel est un guide qui décrit, degré par degré, les moyens à prendre pour établir un programme d'éducation du personnel, en cours d'emploi.

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Les infirmières aimeront aussi à lire l'ouvrage intitulé "Hospital and Community"; c'est le rapport d'une étude concernant des malades, pris au hasard, dans quatre hôpitaux d'Ecosse. Ces hommes ont tous été traités pour maladies aiguës. L'auteur fait remarquer que les bénéfices retirés par le malade, de son séjour à l'hôpital sont souvent amoindris lors de son retour chez lui et à son travail. La transition est parfois très marquée: de l'hôpital où le malade se sent constamment protégé, à la maison ou un régime spartiate l'attend parfois. Les soins à l'hôpital ne sont qu'un épisode des soins généraux dont le malade a besoin et auxquels les services de santé devraient contribuer.

### *Je suis infirmière!*

Durant la visite de Mlle M. Avery, secrétaire générale de la Fédération Royale des Infirmières d'Australie, nous avons eu le privilège de voir le film: "I am a Nurse." Durant 11 minutes, la vie d'une étudiante infirmière se déroule tout simplement sous nos yeux. Ce film a été préparé par le

gouvernement d'un état d'Australie pour fins de recrutement et a été largement distribué dans tout le pays. Un autre film sur les carrières ouvertes à l'infirmière diplômée est en voie de préparation, sous les auspices du même gouvernement.

### *Vos malles sont-elles faites?*

Vous devez être sur le point de faire vos dernières emplettes, d'époussetter vos sacs de voyage et de vous préparer pour le 28ième Congrès biennal.

Rien n'a été épargné pour faire de ce congrès une expérience vraiment éducative. Des conférenciers intéressants ont été invités; puissent les connaissances et les opinions qu'ils nous exposeront dans les divers domaines de la profession être une inspiration pour celles qui considèrent le nursing comme leur responsabilité envers la population canadienne que nous sommes appelées à servir.

Les infirmières du Manitoba, aidées de celles de Saskatchewan ont travaillé de concert à rendre cette visite mémorable.

Bon voyage aux congressistes!

## *Sélection*

### **Importance du dosage ingéré et excrété**

L'importance des mécanismes qui servent à la préservation du milieu intérieur est connue depuis longtemps. Toutefois, durant ces deux dernières années, grâce aux efforts combinés des biochimistes, des physiologistes, des pédiatres, des chirurgiens et des internistes, nous possédons une meilleure compréhension du métabolisme de l'eau et des électrolytes. L'application de ces connaissances a permis de grandes innovations en médecine clinique et en chirurgie au point de prévenir certaines mortalités, autrefois inexplicables.

Conventionnellement, nous séparons les fluides du corps en deux parties: les fluides qui sont dans les cellules et les fluides qui sont en dehors des cellules, en d'autres termes: en liquides intracellulaires et en liquides extracellulaires. D'autre part, ce liquide extracellulaire se subdivise en liquide interstitiel, c'est-à-dire le liquide où baignent les cellules et en liquide intravasculaire, c'est-à-dire le plasma.

Ces liquides in toto représentent 70 pour cent du poids d'un individu. La répartition pour les différentes catégories est la suivante:

Liquide intracellulaire:	50%
Liquide extracellulaire:	
1) interstitiel:	15%
2) intravasculaire:	5%

Ces fluides du corps ne sont pas composés d'eau seulement. Ce sont des solutions complexes contenant des sels, des constituants organiques et des protéines. Le volume normal et la composition de ces fluides sont maintenus chez l'individu sain comme chez l'individu malade par de nombreux mécanismes: les forces osmotiques, l'activité métabolique cellulaire, les glandes surrénales et le lobe postérieur de l'hypophyse, les reins, les systèmes cardiovasculaire, respiratoire et gastro-intestinal.

Ces facteurs contribuent à la régulation homéostatique de l'équilibre aqueux et électrolytique; le rein toutefois, demeure l'organe le plus important et c'est grâce à ses réajustements que les altérations des fluides du corps peuvent être corrigés.

Pour avoir une connaissance exacte de la balance aqueuse et électrolytique d'un individu, il faudrait faire appel à des examens

# New pediatric findings' show **Baby's Own Tablets** **safe**

"even for babies as young as two months"

# **effective**

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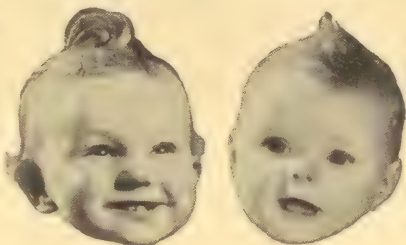
One large group of infants suffered constipation, another group intestinal disturbances and malaise, coincident with teething.

The result from the studies were as follows . . .

**ALL CONSTIPATED BABIES** were relieved with complete easing of straining at stool, gas discomfort, restlessness and crankiness.

**ALL TEETHING BABIES** suffering concomitant gastrointestinal disturbances and malaise were relieved except one. Disturbed sleep, restlessness, crankiness were relieved as well as anorexia and constipation when present.

**EMINENTLY SAFE** — "Throughout the study . . . in no instance was there any untoward reaction; no cutaneous eruptions or other allergic manifestations,



no petechiae, no rise in rectal temperature, no alteration in cardiac and respiratory function, no vomiting or diarrhea, no oliguria, no albuminuria. No significant changes were observed in weight, growth, development or hemoglobin before and after the period of medication."

Pleasant, convenient **BABY'S OWN TABLETS** provide Phenolphthalein  $\frac{3}{16}$  grain, mildly buffered with Precipitated Calcium Carbonate  $\frac{1}{2}$  grain, and Powdered Sugar q.s.

Send for a sample supply and literature citing references.<sup>1-12</sup>

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longs et compliqués qui réellement sont incompatibles avec l'urgence que présente fréquemment la clinique. Il nous faut alors recourir à des moyens plus rapides qui, quoique moins précis, son suffisamment élaborés pour permettre une thérapeutique efficace. Ces moyens, vous les connaissez :

1. *Le sens clinique du médecin*: c'est évidemment d'une importance capitale. Le médecin doit connaître les différentes variations de l'équilibre aqueux et électrolytiques vis-à-vis des différents états pathologiques avant de prescrire les solutés variés.

2. *Le dosage ingéré et excrété*: c'est un moyen simple, peut-être même vulgaire mais c'est un indice sûr. Il faut connaître ce qu'un malade absorbe et excrète chaque jour avant de procéder au remplacement. Certains états pathologiques comme l'aspiration au Wangenstein, les diarrhées profuses, les vomissements abondants et répétés, les occlusions intestinales, les hémorragies de toutes sortes, les états de choc tout particulièrement chez les brûlés, l'administration de diurétiques et plusieurs autres amènent des perturbations aqueuses et électrolytiques d'une importance extrême. Ce déséquilibre

doit être corrigé promptement sinon l'individu s'achemine fréquemment vers la mort. La balance ingérée et excrétée servira alors de guide pour calculer la quantité de liquide à administrer.

3. *Le dosage biochimique des différents électrolytes*: sodium, potassium et calcium sanguin, chlorures plasmatiques, réserve alcaline, protéines totales et fractionnées... aidera le clinicien à prescrire le soluté électrolytique approprié.

Le rôle de l'infirmière est donc important dans la réhydratation des malades autant par sa contribution à enregistrer rigoureusement les ingestas et les excrétas qu'à bien voir à ce que la quantité des liquides soit donnée sur une période de 24 heures. Il est inutile de procéder adéquatement à une réhydratation si cette règle simple n'est pas observée.

Cet article ne constitue qu'une esquisse du problème de l'équilibre aqueux et électrolytique. Notre seul but était de vous montrer la part active que vous jouez dans le traitement.

— par le docteur GUY GERMAIN  
dans "Prisme" — Journal de l'école  
de l'hôpital Notre-Dame, Montréal.

## A Memorial to Marion Lindeburgh

Just over a year has gone by since Canada lost one of her most admired and beloved nursing leaders. The death of Marion Lindeburgh at Victoria in March, 1955, brought to a close the distinguished career of a



MARION LINDEBURGH

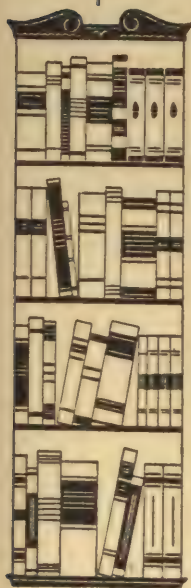
woman who is enshrined in the hearts and memories of countless nurses.

The nursing profession can record with pride her many contributions — the teaching that inspired hundreds of students, the wise and thoughtful counselling, the production of a curriculum for schools of nursing and the discharging of high offices with sincerity and purpose. Yet, a major part of Miss Lindeburgh's contribution to nursing can only be recorded in the hearts of people who knew her, for much of her greatness consisted of innumerable acts of loving kindness on behalf of friends, colleagues and students. Her life was dedicated to helping others and to what she termed "the grand profession."

Since Miss Lindeburgh's death many nurses across Canada have expressed the hope that a fitting memorial might be created to honor this distinguished leader whose contribution to nursing has been so outstanding. What form such a memorial should take has been the subject of many discussions over the last twelve months. The general



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By IRA L. FERGUSON, Ph.D., Professor of Education and Hygiene, School of Education, Tuskegee Institute and ELIZABETH S. FERGUSON, B.A., Instructor of the Mathematics of Drugs and Solutions, School of Nursing, Tuskegee Institute. About 150 pages  $8\frac{1}{2}'' \times 11''$ , illustrated.

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consensus seemed to be that Miss Lindeburgh would best be remembered through the establishment of a fund designed to promote what she herself worked so tirelessly to encourage — the education of nurses.

While Miss Lindeburgh's work was national in its scope, the vital part was centred at McGill University, where for 21 years she was associated with the School for Graduate Nurses, first as assistant to the Director, and then as Director. It is felt, therefore, that McGill University is the appropriate place to set up such a fund. The initiative in this matter has been taken by the Alumnae Association of the School

for Graduate Nurses which, at a recent meeting in Montreal, decided to sponsor "a memorial fund for Dr. Marion Lindeburgh to take the form of a scholarship fund for the School for Graduate Nurses," and to seek contributions from nurses in every part of Canada. It is hoped that the generosity of Canadian nurses will result in the creation of a scholarship fund large enough to serve as a worthy memorial to Marion Lindeburgh's devoted work in the field of nursing education.

Contributions may be sent to the **Secretary, Alumnae Association, School for Graduate Nurses, McGill University, 1266 Pine Avenue West, Montreal.**

## Book Reviews

**Textbook of Medicine For Nurses**, by J. W. Joule, M.R.C.P. 524 pages. H. K. Lewis & Co. Ltd., 136 Gower St., London, W.C.1. 2nd Ed. 1955. Price £1/7s/6d.

*Reviewed by Miss Jean Mackie, General Hospital, Calgary, Alta.*

The physical features of this book are quite attractive. It is well bound. The print is easily read and is on high gloss, durable paper. Illustrations (black and white) and graphs are clear and very helpful though not as numerous as might be desired.

The title of the book indicates that the author is offering information which he considers suitable for use by student nurses. I feel this information is too brief and oversimplified. How much medical knowledge does a nurse need to have, or be exposed to? Dr. Joule, himself, is uncertain as evidenced by two somewhat contradictory statements in the preface "Nursing is essentially a humane calling... but some knowledge of the disease process at work is necessary if the nurse is to do justice to her patient and herself." "Intelligent observation backed by a sound knowledge of the condition is necessary if life is to be saved." There is a vast difference in the implications of the words "some" and "sound." Admittedly, it is difficult to determine what information is required in either category. Most nurses would agree that a "sound" knowledge of medicine is highly necessary in this era of complex nursing responsibilities.

There is a short chapter devoted to "Diet

in Health and Disease" which is far too brief to serve any real purpose. The same could be said of the chapters on drugs and special procedures. Insufficient explanation is given in these chapters to make their inclusion in a textbook of medicine worthwhile. This space could have been more advantageously used to discuss such topics as geriatric nursing, nursing in long-term illnesses, the theory of stress reactions, the importance of rehabilitation and the social significance of disease. None of these is included. I feel we should expect them in a textbook of medicine if we accept the premise that it is desirable to have such a textbook for nurses.

**Psychology in Nursing Practice**, by L. Crow, Ph.D., A. Crow, Ph.D. and C. Skinner, Ph.D. 448 pages. The Macmillan Company of Canada Limited, 70 Bond Street, Toronto 2, Ont. 2nd Ed. 1954. Price \$5.00.

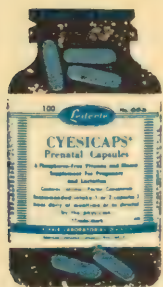
*Reviewed by Miss Jean Whiteford, Instructor, Winnipeg General Hospital, Winnipeg.*

The thought-provoking caption "Skill versus Skill" and such a statement as "Someone defined tact as cultural common sense" hold the interest of the reader. The second edition of this book has, in a very concise manner, reviewed the principles of psychology and emphasized how they may be applied to nursing. The terminology can be understood by a preclinical student. The organization of ideas starting with the nor-

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mal personality and following through the discussion on abnormal behavior of people, is quite comprehensive. The sections dealing with emotions and maturity are well developed. The sections on suggestions for study and principles of learning are written to meet the needs of the student nurse and are valuable in helping the student form good study habits.

Whether this book is used as a text or a reference book, it is valuable as a guide to those who are concerned with the development of psychology. The information will help the nurse to develop a basis for her course in psychiatry. The bibliography, questions and exercises included at the end of each chapter are a helpful addition to this text.

#### **Nursing Manual for Psychiatric Aides,**

by Annie Laurie Crawford, B.S., and Virginia Curry Kilander, B.S. 93 pages. The Ryerson Press, 299 Queen St. W., 2B, Toronto, Ont. 1954. Price \$2.00.

*Reviewed by Patricia McMillan, Provincial Mental Hospital, Ponoka, Alta.*

This manual is divided into two units: 1. Getting Acquainted and 2. Nursing the Patient. Each chapter concludes with suggested films, references and exercises. The exercises are very practical and should be particularly helpful in an inservice educational program.

The method of outlining significant data relating to the various reaction types which might be observed is especially noteworthy. These outlines are accompanied by practical suggestions for nursing care. Discussion of basic procedures, for example admitting a patient, is supplemented by samples of conversation to serve as a guide to the novice.

This is an excellent manual for the orientation of any newcomer to the psychiatric field.

**A Textbook of Chemistry,** by Stella Goostray, R.N., B.S., M. ED. and J. Rae Schwenck, A.B., CH. E. 426 pages. The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2, Ont. 7th Ed. 1954. Price \$4.75.

*Reviewed by Miss Grace Smith, Instructor Royal Columbian Hospital, New Westminster, B.C.*

The intention of the authors was to increase the selected content from the fields of inorganic, organic and biological chemistry as changing needs of student nurses have indicated and in accord with the latest advancements in nursing school curricula. The original objectives as stated in the preface have been kept in mind.

The table of contents is clearly and concisely outlined. An outline of contents at the beginning of each chapter stimulates interest. Illustrative material, graphic forms, outlines and tables are generously distributed throughout the book. A concise summary, questions and exercises are at the end of each chapter. Pertinent points and principles are written in italics in the subject matter. The appendices at the end of the book give the basic mathematics of chemistry with tables of the technical data, arithmetic problems and answers, suggested units of study, weights and measures, and removal of stains. A table of international atomic weights is conveniently placed on the back inside cover.

The content of the book gives a broad concept of chemistry which will furnish a foundation and support for the relative subjects in the curriculum. "In nursing and allied arts, chemistry is a tool to be used in the daily practice of the vocation." Chapter two, "Our World is made of Simple Things" starts with a survey of matter which is clearly and simply arranged. The content of the chapter adequately explains the graphic outline. An evaluation of the implications of the atomic age in its relationship to applied chemistry is presented. Oxygen, the preserver of life and the supporter of combustion; carbon, the most versatile element; and water, the compound most important to life are broadly presented. An increasing interest in electrolytes is evident in medicine and nursing. The student meets the problem of understanding something about electrolytes in fluid balance early in her bedside nursing experience. There is good source material here on acids, bases and salts. The field of organic chemistry deals with the hydrocarbons and their simple derivatives. Simple classes of compounds and the chemical principles are described in order to provide the foundation for the subsequent presentation and understanding of the substances which our bodies use, together with the changes these substances undergo.

"Our health, our happiness and what we become are in a part dependent upon the food we eat." Food requirements and essential food elements are discussed so that the obvious functions of foods are understood. The story of the chemical changes occurring during the digestion of food is covered. Consideration is given to the chemicals and chemical processes influenced by substances such as vitamins, hormones and enzymes. An appreciation of the role the circulating blood

plays in supplying oxygen and nutrients to every cell in the body must be realized by the student nurse. The chemistry of blood in this chapter may be easily correlated with the anatomy course. The latter section of this chapter deals with "The Chemistry of Pathological Conditions." The section "Chemistry of Tissues and Glands" indicates again the role of the blood as a transporting medium.

The last chapter highlights the subject matter previously presented. The importance of chemical research to mankind is evaluated in regard to the extension of knowledge and the effectiveness of cures. The book concludes with the statement, "Future generations of mankind will enjoy more fruitful lives because of the work of our generation." Nurses using this textbook will find it of value in their own field and in understanding other fields of applied science.

\* \* \*

Investigations are proceeding to try to determine what causes some people without syphilis to show a positive Wassermann. So far it has been discovered that some of these individuals are probably destined to have lupus erythematosus.

## In the Good Old Days

(*The Canadian Nurse* — JUNE, 1916)

Eye specialists have been very interested in the work of the school nurses. They examine the children's eyes and prescribe glasses where needed. We have an arrangement with a manufacturing oculist who lets us have glasses at a reduced rate and the parents, as they are able, pay us 25 or 50 cents per week until the glasses are paid for.

\* \* \*

There are 240 registered nurses in the province of Manitoba. It is regrettable that so few are members of our Association.

\* \* \*

For the first time the Canadian Nurses' Association is holding its annual convention in Western Canada. It is meeting in Winnipeg June 11 to 16. The nurses of Manitoba have often felt left out of things but now we will be at the centre of nursing thought for four days.

\* \* \*

For the person of only fair digestion, cheese is one of the most digestible of foods. It needs good mastication and to be well mixed with farinaceous matter of some kind.

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\* \* \*

Two provinces, Alberta and New Brunswick, have reported the passing of Bills of Registration. Our hearty congratulations!

\* \* \*

Every school of nursing worthy of recognition should be required to employ a staff, however small, of paid teachers, so that the education of nurses would not be dependent on the whims or personal convenience of visiting physicians.

## Nursing Sisters' Association

The initial plans for the national convention of the nursing sisters of Canada were announced by Mrs. E. A. Rabson, national president, at the annual dinner meeting of the Winnipeg unit. This event is to take place in June with Mrs. B. Finger acting as social convener for the occasion.

Miss I. Kemp, the newly elected Winnipeg president, introduced the members of her executive: N. Hearn, vice-pres.; Mrs. S.

Alcock, treas.; Mrs. W. Forbes, rec. sec.; Mrs. G. Noble, corr. sec.; Mrs. J. E. Robinson, social convener; Mrs. S. E. Macbeth, publicity; Z. Harman, membership; Mrs. C. W. Davidson and M. Muir, sick visiting; I. Barton, Poppy Day; E. Hudson, Memorial Day; Mrs. H. Sharp and A. Nicholson, advisory.

\* \* \*

At the annual meeting of the Halifax Branch, held in the Nova Scotia Hotel, the following members were elected to the executive: M. McIsaac, pres.; J. MacLean, vice-pres.; G. Hopkins, sec.; M. Romans, treas. Committees: Entertainment, Mrs. M. Lewis, A. Egan and M. McGlashen; sick visiting, M. Burke, M. Betts; recruitment, E. Purdy.

\* \* \*

The thirty-first annual meeting of the Toronto unit was held early in the year. The new executive includes the following members: B. Seeds, pres.; L. Fair, 1st vice-pres.; E. Beardmore, 2nd vice-pres.; M. Picton, treas.; J. Deyell, rec. sec.

## Ontario

The following are staff changes in the Ontario Public Health Nursing Services:

**Appointments** — *Madeleine des Landes* (St. Vincent de Paul Hosp., Sherbrooke, U. of Montreal) to Ottawa Dept. of Health. *Ethel Irwin* (Toronto Gen. Hosp., U. of Toronto) formerly senior nurse to the position of supervisor, Timiskaming H.U. *Annie Boyd* (Hamilton Gen. Hosp., U. of T.) from the position of supervisor to director, Hamilton Dept. of Health. *Barbara (Paynes) Wright* (Victoria Hosp., London, U. of West. Ont.) to the Scarborough B. of H.

**Resignations** — *Agnes (Harley) Haygarth* (Hamilton Gen. Hosp., U. of T.) from the position of director and *Mary Schaffter* (Birkenhead Gen. Hosp., England, U. of T.) from Hamilton Dept. of Health. *Ruth (Roszell) Neilson* (T.G.H., U. of T.) from London Dept. of Health. *Doris (Kirkwood) Burnes* (Cornwall Gen. Hosp., U. of West. Ont.) from Middlesex Co. School Health Service. *Lucy Miocich* (St. Joseph's Hosp., Port Arthur, U. of Ottawa) from the Port Arthur B. of H. *Annie Sorbie* (Queen's Institute of District Nursing, Health Visitor Cert.) from Oxford Health Unit. *Jean (Guild) Watson* (T.G.H., U. of T.) from Scarborough Township B. of H.



The power of human thought is infinite, yet human wisdom accumulates very slowly, only through infinite testing and sifting. There is no more precise and powerful way of recording and expressing thought than the written word, no surer means of testing it than by reading the written word. These would be reasons enough to be sure that books and reading will always remain the largest influence in any modern civilisation that allows for growth of the human spirit. But it is also true that there is a human need to share experience even when it is not of overwhelming significance. This need is the root of all art, the bond between every artist and his audience. Experience is shared daily, in every communication between men.

— RODERICK HAIG-BROWN

\* \* \*

I am a great believer in luck. I find that the harder I work the more I have of it.

— STEPHEN LEACOCK



Miss Alice Wright, executive secretary of the Registered Nurses' Association of British Columbia, is seen here as she boards a Trans-Canada Air Line Super Constellation at Montreal airport, Dorval, on April 15, en route to Copenhagen and Geneva. She attended a meeting of the Membership Committee of the International Council of Nurses in Copenhagen and later was an observer at the World Health Assembly. In between these meetings Miss Wright had an opportunity to visit the national offices of the nurses' associations in several European countries.



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## News Notes

### ALBERTA

#### DISTRICT 2

##### CAMROSE

Chapter activities were numerous and varied during the year 1955. An active educational program was carried out to the benefit of all attending the meetings. Members participated in the Civil Defence Institute in Disaster Planning presented early in the year at St. Mary's Hospital. Assistance was given to the Red Cross Blood Donor Clinic. A donation was made to assist in purchase of a movie projector which would then be available for chapter functions. A gift of equipment was made to the new Civic Center. Present plans call for a refresher course to be held as soon as arrangements can be completed.

The slate of officers for the coming year is: Mrs. J. Danforth, chairman; Mrs. L. Hesbeth, vice-chairman; Mrs. R. Andrews, sec.-treas.; Mrs. E. Greenberg, program convener.

##### WETASKIWIN

The following members have been elected to the executive for the current year: Mrs. J. Bunnin, pres.; Mrs. E. Good, vice-pres.; Mrs. F. Albers, sec.-treas. Six chapter members are assisting with the St. John's Ambulance Course presently being given. The annual Spring tea was held early in April. Financial assistance to aid in the purchase of a midwifery kit and refills was sent to Ponoka to assist in providing such kits for "CARE."

#### DISTRICT 3

##### CALGARY

Mrs. A. Stewart, representing the private duty section of the chapter, reported at a recent meeting that refresher courses for this group have resumed. The first lecture was to be devoted to heart surgery. The annual Bursary Tea was held in February and a chapter supper meeting took place in April at the Colonel Belcher Hospital. Rededication services for Protestant nurses were held in May and a potluck supper meeting is planned for mid-June.

##### Holy Cross Hospital

The annual Blossom Tea of the alumnae association was held in May with a bazaar and sale of homecooking as an added feature. The 50th anniversary of the school of nursing is to take place late in 1957. Plans are already underway for a homecoming to

celebrate this important occasion. Special events for the graduating class have included a banquet and social evening for the 60 members of this group. News of the graduates includes the following items: S. Bayes is working in Calgary following her return from Bermuda. E. (Howg) Wilkins is engaged in office nursing in Las Vegas. J. Stanford recently took over her duties as matron of Cardston Municipal Hospital. M. Swidiszski is working in Alaska. M. Bittman is doing postgraduate work in surgery at St. Michael's Hospital, Toronto. B. (Cush) Keen is in charge of Nursing Services. P. Velker has joined the U. S. Navy. P. McMillan is doing missionary work in a leper colony in Addis Ababa. M. Macomber is with the Trans-Atlantic division of T.C.A.

## DISTRICT 7

### EDMONTON

Twenty-four members attended the annual chapter meeting at the St. John's Ambulance House early this year. The following slate of officers was elected: E. Taylor, past chairman; R. Ball, chairman; D. Watson, vice-chairman; I. Reesor, 2nd vice-chairman; M. Thomson, treas.; B. Farquharson, sec. Committees: Program, Mrs. M. Alexander and B. Lea; Local Council of Women, M. Fraser.

### VEGREVILLE

During 1955, the monthly chapter meetings had an average attendance of 13 members who engaged in a busy round of activities. As one project the members of the graduating class of St. Joseph's General are entertained each year. This season a novel Chinese dinner was arranged by Miss Little, Mrs. Dougan, Mrs. Moar, Miss Patrick and Miss Knapik. It was held at the home of Dr. Reid with the hostesses appearing in appropriate costume. The nurses of this area are cooperating wholeheartedly with the civil defence program of the town. In connection with this, members devoted one meeting to a TV presentation of civil defence in action. Delegates attended the A.A.R.N. convention in Calgary bringing back interesting accounts of the sessions. Mrs. C. Van Dusen was an honored guest and speaker at one meeting when she discussed the structure and function of the provincial association. Some time was devoted to money-making projects and to special programs such as the annual Christmas party for hospital patients.

The executive for the current year includes Mrs. R. Edmund, pres.; Mrs. N. Moar, vice-pres.; M. Patrick, sec. treas. In addition a program committee has been formed to organize educational activities for the year.

## BRITISH COLUMBIA

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been undertaken as a major project by this chapter. Convened by R. Hartwig and L. Lang, a St. Patrick's Day dance and a fashion show by The Hudson's Bay Company proved most profitable in raising the necessary funds. Mrs. I. Cooper is to be the chairman of the Loan Cupboard.

#### PENTICTON

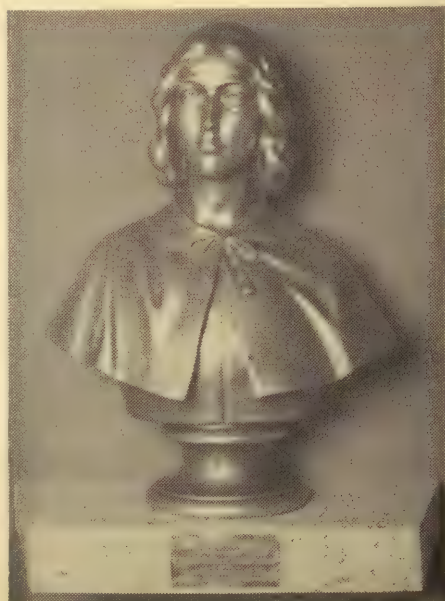
Thirty-five members attended a recent chapter meeting presided over by Mrs. A. Mason. The guest speaker, Dr. R. E. Earnshaw, of the Veterinary Hospital, reviewed some of the similarities and differences in medical and veterinary work. Useful hints in first aid and the emergency treatment in some cases of poisoning were suggested. The importance of animals as a source of infection to humans was discussed, in particular incidence of rabies and ringworm.

#### VANCOUVER

##### *St. Paul's Hospital*

In October, 1955, at their Homecoming the alumnae association presented the Sisters of Charity and Providence with a bronze-colored bust of Jeanne Mance. It was placed in the foyer of the new auditorium in the nurses' residence. The presentation was made in appreciation of the work and years of service of Reverend Sister Columkille, former director of nurses during the years 1938-52. She is now Sister Superior of Notre Dame Hospital, North Battleford, Sask.

Plans are already underway for a bazaar to be held in December. The "Dollar and Under" theme is to be continued with aprons featured as one specialty and young children's clothing as another. It is planned to hold periodic working bees at the nurses' residence to prepare the articles for sale.



JEANNE MANCE

A Spring Coffee Party was held in early May and a dance honoring members of the graduating class took place late in April. Dr. E. Harrison discussed chest surgery and its nursing care at the April meeting of the alumnae association.

Mrs. D. (Bird) Kelly is on the staff of the Seattle Cancer Clinic. Working in the same city are S. Jarvis and M. Kelly. B. Metens is in charge of a hospital at Snoqualmie Pass. Mrs. (Innes) Brown is presently giving demonstration and practice sessions in "Body Mechanics" in Penticton.

## MANITOBA

### WINNIPEG

#### General Hospital

Miss P. Desjardins, executive director, Manitoba Branch of the Canadian Mental Health Association, was the guest speaker at the March meeting of the alumnae association. A native of Manitoba, Miss Desjardins engaged in social work with the Family Bureau and the Child Guidance Clinic before going to Panama to assist with the United Nations project of mental health programs. She later acted as consultant for a mental health conference of Latin-American countries under the direction of the World Federation of Mental Health.

Miss Desjardins made some very interesting observations about the mental health of Canadians. One of every 12 children born in Canada needs psychiatric help at some time; one-half of our hospital beds are being used for the care of mental patients; one-third of Canada's medical budget is used for the care of the mentally ill. One of the greatest problems that must be overcome to assure the success of mental health programs is to overcome public ignorance regarding mental disease and its treatment.

## NEW BRUNSWICK

### MONCTON

Two chapter meetings have been held recently in the nurses' residence of Moncton Hospital. Reporting on the progress of the Nursing Education Committee, Mrs. L. Colwell told of the Institute for Instructors in Nursing which had been held under the leadership of Miss L. MacKenzie, Clinical instructor of the Wellesley Division, Toronto. A sub-committee studying student rotation in the various clinical fields met recently. Miss K. McRae and Mrs. M. Rattray are teaching home nursing to members of the St. John Ambulance Association. Eleven student nurses of the Hotel Dieu and 42 students of the Moncton Hospital received their caps at exercises earlier this year.

A questionnaire from provincial office was reviewed and a committee formed to summarize the answers. F. Hickman and Mrs. E. Johnstone reported on a project which they had recently undertaken. Representatives of the Canadian National Railways

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**WORLD'S WHITEST WHITE**

addressed the members at one of the chapter meetings in connection with the Nurses' Special to the Biennial Convention in Winnipeg. Colored films added to the pleasure of hearing about the trip to Manitoba. Senior student nurses were guests of honor on this occasion.

#### Nurses' Hospital Aid

Members elected to executive positions for the current year include: K. Richardson, hon. pres.; Mrs. R. Lewis, pres.; Mrs. W. Buxton, 1st vice-pres.; Mrs. B. MacAuley, 2nd vice-pres.; Mrs. C. Colwell, rec. sec.; Mrs. W. McCully, corr. sec.; Mrs. J. H. Pettigrew, treas. Souvenir book marks of



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## THE MOUNTAIN SANATORIUM

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POSTGRADUATE COURSE  
IN THE IMMUNOLOGY,  
PREVENTION & TREATMENT  
OF TUBERCULOSIS.

This course is especially valuable to those contemplating Public Health, Industrial, or Tuberculosis Nursing.

*For further information apply to:*

Director of Nursing,  
Mountain Sanatorium,  
Hamilton, Ontario.

the old and new Moncton hospitals are proving to be a regular source of income. A Chinese auction highlighted the entertainment portion of one meeting recently. Mrs. D. Van Buskirk has been appointed convener of the graduation dinner and dance.

### ONTARIO DISTRICT 5

TORONTO

#### *St. Michael's Hospital*

The alumnae association held a bazaar early in April in the nurses' residence. M. Larkin, tuberculosis consultant, presented a most interesting paper on this disease at a Samaritan Club meeting earlier this year.

### DISTRICT 8

OTTAWA

#### *Civic Hospital*

"Success to the end of the road" was the wish expressed for Miss Effie C. McIlwraith by Mayor C. Whitton at ceremonies marking Miss McIlwraith's retirement. A graduate of St. Luke's General Hospital, Ottawa, she practised her profession in Alberta and British Columbia before assuming the duties which she has carried out so devotedly for





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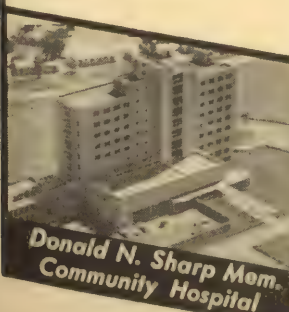
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of Southern California

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for

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Degree in nursing education with  
experience required.

Salary open

APPLY: ALEX E. NORTON, Superintendent

NEW ROCHELLE HOSPITAL

NEW ROCHELLE, NEW YORK

## ASSISTANT HEAD NURSES

for

270-bed Sanatorium

Corner Brook, Newfoundland

This hospital has a thoracic surgery unit & includes a fully equipped Outpatient Dept. Salary starts at \$2,200 per annum. Accommodation available in new nurses' home at \$40 per mo., deductible from salary. Uniforms & laundry free. 44-hr. wk. 8 hr. duty. 4 wk. vacation a yr. Statutory holidays & sick leave with pay.

The city of Corner Brook, on the west coast of Newfoundland, has a pop. of about 20,000 & many types of recreational facilities are available both winter & summer.

Apply Director of Nurses,  
West Coast Sanatorium.

the past 30 years. A purse was presented to Miss McIlwraith by the hospital trustees in recognition of her faithful service.

## MONTREAL

### General Hospital

A demonstration of the clinical psychosomatic approach to a patient suffering from dermatitis was a highlight of a recent alumnae meeting. The team consisted of a physician, a psychiatrist, a psychologist, a sociologist and a nurse. Dr. Wittkower directed the activities of the panel.

S. Williams, L. Wolf, N. MacRae and G. Gatehouse, are presently enrolled at the School for Graduate Nurses, McGill University. E. Gilbert, who is completing her studies at McMaster University, plans to rejoin the hospital staff at the end of the academic year. A. Christie attended the course in civil disaster nursing at the Civil Defence College, Arnprior, which was held late in March. M. Ford recently resigned from the staff to be married. She plans to return to the staff of the Caribou Health Unit after her marriage.

Recent visitors to the hospital have included Mrs. Janssen of Holland, a practising midwife and member of an underground unit during World War II through which many Canadian airmen reached safety. Miss Gertrude Hall also visited the hospital recently.

A reunion of all the graduates of the school of nursing is being planned to take place September 20, 21 and 22. It is hoped that as many graduates as possible will arrange to be in attendance.

## QUEBEC CITY

### Jeffery Hale's Hospital

Mrs. (Parks) Davidson has recently returned to the staff. S. Gray and J. Golden are in charge of the Outpatient Department of the new building following completion of postgraduate study at the New York Polyclinic.

## SASKATCHEWAN

## SASKATOON

### City Hospital

The alumnae association held its annual membership tea early in February. The event was well attended with the proceeds of a homebaking sale being used to increase the Chapel fund. A room has been set aside for use by the association in the new wing. Furnishing the room is to be a major project of the association for the next few years.

Dr. Hamdi was the guest speaker for the March meeting. A native of Egypt, he gave a very interesting talk concerning the history and living conditions of the Middle East.

# SOUTHWEST REGIONAL HOSPITAL COUNCIL

Enjoy your nursing in the warmest, sunniest part of Saskatchewan. Vacancies exist at the following hospitals:—

## CABRI UNION

2 G.D. Nurses \$230-260

## CLIMAX UNION

1 G.D. Nurse \$255

## EASTEND UNION

1 G.D. Nurse \$230 - 260

## LEADER UNION

3 Graduate Nurses \$230 - 260

## MAPLE CREEK UNION

2 G.D. Nurses \$225 - 255  
(Close to Cypress Hills)

## PRELATE UNION

2 G.D. Nurses \$255

## SHAUNAVON UNION

2 G.D. Nurses \$255

Further details of excellent conditions of service may be obtained from the Director of Nursing at the individual hospital or from the undersigned:

**PHILIP RICKARD, REGIONAL HOSPITAL CO-ORDINATOR**  
**SWIFT CURRENT, SASKATCHEWAN**

## REGISTERED NURSES

are required by the  
DIVISION OF MENTAL HEALTH  
for the

ACTIVE TREATMENT CENTRE  
FALCONWOOD HOSPITAL  
CHARLOTTETOWN, P.E.I.

## POSITIONS AVAILABLE

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Salaries \$2,000 - \$3,600

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## PROVINCE OF NOVA SCOTIA DEPARTMENT OF PUBLIC HEALTH

### BURSARIES FOR TRAINING IN PUBLIC HEALTH NURSING

Applications are invited from Graduate Nurses wishing to train in the above. Bursaries to successful applicants — \$125.00 per month if single, or \$175.00 per month with dependents, plus tuition, books (up to \$25.00) and travel expenses.

Nurses who have an entrance into university may be taken on our staff for a period of field work before going to university this Fall.

Further information may be obtained from:

Miss Phyllis J. Lyttle, R.N.  
Superintendent of Nurses  
Department of Public Health  
Box 488, Halifax, Nova Scotia

Application forms may be obtained from the

NOVA SCOTIA  
CIVIL SERVICE COMMISSION

P.O. Box 943, Provincial Administration  
Building, Halifax, Nova Scotia

or  
by telephoning 2-7341 - Branch 230



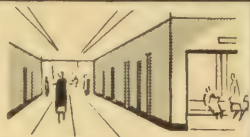
# 50 Nurses Needed...

## HAMILTON, ONTARIO

*The three city-owned hospitals, the General, the Mountain and the Nora-Frances Henderson, have recently undergone an expansion program and are in immediate need of a minimum of 50 Registered Nurses.*



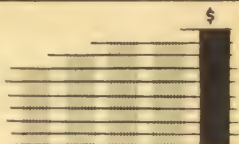
Recognized as one of the most modern-equipped hospitals in Canada, the Hamilton General offers the Registered Nurse working and recreational facilities second to none.



Situated in the heart of what has been termed the "Golden Horseshoe", Hamilton is a city practically equidistant to Toronto and Buffalo, big enough to be interesting, yet small enough to be friendly and hospitable to the individual.



The rates of pay to Registered Nurses are the highest in the Province of Ontario. For Registered Nurses who work rotating hours of service, the beginning salary is \$53.00 per week. The daily rate is \$10.50 for each eight-hour period of duty.



Hours of duty: (a) 8 hour day—42 hours weekly average—rotating service. DAYS: 7 a.m. to 3.30 p.m. or 10 a.m. to 7 p.m.; EVENINGS: 3 p.m. to 11.30 p.m.; NIGHTS: 11.15 p.m. to 7.15 a.m. These schedules include one half hour for each meal and 15 minutes for morning coffee. (b) Two days off three successive weeks and one day off every fourth week. (c) All statutory holidays or compensatory time.



VACATIONS: Registered Nurses after one year of service receive 3 weeks vacation with pay. It is less than 200 miles to the beautiful Muskoka Lakes District, less than 2 hours to the U.S. border.



Here is a unique opportunity for Registered Nurses to come to a thriving community where your opportunities are unlimited.  
For further particulars write:

**HAMILTON GENERAL HOSPITAL**  
Barton Street East  
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# NURSING WITH INDIAN AND NORTHERN HEALTH SERVICES



## OPPORTUNITIES FOR REGISTERED HOSPITAL NURSES, PUBLIC HEALTH NURSES, and NURSING ASSISTANTS or PRACTICAL NURSES

for Hospital Positions and Public Health Positions in Outpost Nursing Stations, Health Centres and Field Positions in the Provinces, Eastern Arctic and North-West Territories.

### SALARIES



- (1) Public Health Nursing Supervisors: up to \$4,620 depending on qualifications and location.
- (2) Directors of Nursing in Hospitals: up to \$4,620 depending on qualifications and location.
- (3) Public Health Staff Nurses: up to \$3,600 per year depending on qualifications and location.
- (4) Hospital Staff Nurses: up to \$3,420 per year depending upon qualifications and location.
- (5) Nursing Assistants or Practical Nurses: up to \$185 per month depending upon qualifications and location.

- Room and board in hospitals — \$30 per month. Statutory holidays. Three weeks' annual leave with pay. Generous sick leave credits. Hospital-medical and superannuation plans available.

- Special compensatory leave for those posted to isolated areas.

For interesting, challenging, satisfying work, apply to — Indian and Northern Health Services at one of the following addresses:

- (1) Regional Superintendent, 4824 Fraser Street, Vancouver 10, B.C.
- (2) Regional Superintendent, c/o Charles Camell Indian Hospital, Edmonton, Alberta.
- (3) Regional Superintendent, 735 New Federal Building, Regina, Saskatchewan.
- (4) Regional Superintendent, 522 Dominion Public Building, Winnipeg 1, Manitoba.
- (5) Zone Supervisor of Nursing, Box 292, North Bay, Ontario.
- (6) Zone Supervisor of Nursing, P.O. Box 3427, St. Roch Branch, Quebec, Que.
- (7) Moose Factory Indian Hospital, Moose Factory, Ontario.

or

Chief, Personnel Division, Department of National Health and Welfare, Ottawa, Ontario.

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- **Why not enjoy these benefits offered by Roosevelt?**

**BASE SALARY** — Begins at \$260 per month, without experience. Experience qualifies for higher starting salary.

**INCREMENTS** — Start after first 6 months and continue annually.

**BONUSES** — \$40 for evening and \$20 for night duty.

**VACATION** — 4 weeks annually.

**HOLIDAYS** — 10 annually.

**LAUNDRY SERVICE**

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**DIRECTOR OF NURSING,  
DEPARTMENT NS,  
ROOSEVELT HOSPITAL  
59th Street West,  
New York City**

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RECOVERY ROOM (1)

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OPERATING ROOM (1)

For new hospital wing

Good personnel policies

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**DIRECTOR OF NURSING  
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# EDUCATIONAL DIRECTOR

*for*

**SCHOOL OF NURSING**

**Saint John General Hospital**

**DUTIES TO COMMENCE JULY 1, 1956.**

**Degree in nursing education with  
experience required.**

**New Educational Department  
opening in March, 1956.**

**Expected registration 200 students.**

**APPLY: DIRECTOR OF NURSING,  
SAINT JOHN GENERAL HOSPITAL,  
SAINT JOHN, N.B.**



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U.S.A. & Foreign — \$7.50 for 3 lines or less; \$1.50 for each additional line.

Closing date for copy and cancellations: 10th of the month preceding the month of publication. All letters should be addressed to: The Canadian Nurse, 1522 Sherbrooke St. W., Montreal 25, Que.

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The University of Alberta invites applications for the position of Director of the School of Nursing. Applications accompanied by a curriculum vitae, transcripts of record, the names of at least 3 references & a recent photograph or snapshot, should be received by the Dean of Medicine, University of Alberta, not later than June 30, 1956.

---

**Director of Nursing for 50-bed (long stay) Children's Hospital** situated by the water at Mill Bay near Victoria. The hospital is fully accredited & plans are almost complete for relocating & rebuilding a new 64-bed & then 96-bed hospital situated by the water at Finnerly Bay in Victoria within the next 12 mo. A very modern suite is available. Successful applicant will be required to register in B.C. Forms of application may be obtained from Administrator, Queen Alexandra Solarium for Crippled Children, Cobble Hill P.O., Vancouver Island, B.C.

---

**Director of Nursing & Nursing Education** for 160-bed General Hospital. Postgraduate course in administration or equivalent experience required. Salary open. Applications should give details of education, qualifications & experience. Apply Administrator, The Victoria Public Hospital, Fredericton, N.B.

---

**Associate Director of Nursing Service for 200-bed General Hospital**, addition under construction at present. Postgraduate course or equivalent experience required. Liberal personnel policies. Apply Director of Nursing, General Hospital, Belleville, Ont.

---

**Director of Nursing Service (Immediately) for 276-bed General Hospital.** Postgraduate course in administration favored, experience preferred. Apply Administrator, St. Paul's Hospital, Saskatoon, Saskatchewan.

---

**Asst. Director of Nursing for 450-bed hospital with school of nursing.** Experienced, preferably with University Certificate of postgraduate training. Salary according to experience. 40-hr. wk. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

---

**Assistant Director of Nursing for 220-bed, 41-bassinet hospital** opened Sept. 1953. School of Nursing. Starting salary: \$300 per mo. Apply Director of Nursing, South Waterloo Memorial Hospital, Galt, Ont.

---

**Supervisor (Nursing Service) for 50-bed General Hospital.** Salary: \$210 plus maintenance. 44-hr. wk., 3-wk. vacation, 10 statutory holidays, 14 days sick leave. Apply Miss M. Jarvis, Matron, Municipal Hospital, Wainwright, Alta.

---

**Superintendent of Nurses (1).** Salary: \$275 per mo. **Graduate Nurses (2).** Salary: \$225 per mo. less \$40 per mo. room, board & laundry. 28-bed hospital, pleasant surroundings, 5 mi. from U.S. border. 40-hr. wk., 4 wk. vacation after 1 yr. service. 1½ days sick leave per mo., yearly accumulative. Nice nurses' residence. Apply The Grands Forks Community Hospital, Grand Forks, B.C.

---

**Evening Hospital Supervisor, Pediatric Supervisor — experienced with P.G. (August)**  
**Head Nurse for Central Supply. Science Instructor** for 200-bed General Hospital. School of Nursing, September classes only. Salary: \$245-\$315. 1 mo. annual vacation, 10 statutory holidays, 1½ sick days per mo. cumulative. 40-hr. wk. Apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

---

**Supervisor of Nursing (Reg'd. Nurse) for modern 47-bed General Hospital** serving district of 10,000. Nursing staff of 26. Starting salary: \$275 per mo. Private accommodation in new nurses' residence. Board & lodging \$50. Please state age, qualifications & references to Administrator, G. R. Baker Memorial Hospital, Quesnel, B.C.

---

**Matron for new 17-bed hospital** located in a beautiful fishing & logging village west coast Vancouver Island. Starting salary \$275 per mo. less \$40 maintenance in lovely furnished 3 room suite 4 wk vacation after 1 yr., all statutory holidays, cumulative sick leave. B.C. registration required. Boat & daily air service. Apply Matron, General Hospital, Tofino, B.C.

# QUEENSWAY GENERAL HOSPITAL

TORONTO 14, ONTARIO

is accepting applications for Employment in all nursing  
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Newest hospital in Toronto, situated on The Queen Elizabeth Way, 12 miles  
from downtown Toronto. Attractive residence facilities available in the new  
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Excellent Salaries and Personnel Policies

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DIRECTOR OF NURSING, QUEENSWAY GENERAL HOSPITAL

TORONTO 14, ONTARIO

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**Operating Room Supervisor for 100-bed west coast General Hospital.** Salary: \$300 per mo. less \$40 for board, residence, laundry. 3 annual increments \$10 per mo. 1 mo. vacation paid after 1 yr. service. 1½ days sick leave per mo. cumulative to 28 days. Transportation allowance up to \$60 refunded after 1 yr. Apply Director of Nursing, General Hospital, Prince Rupert, B.C.

---

**General Supervisors, Operating Room Nurses and General Duty Nurses** for new 150-bed hospital. Starting salary for Registered General Duty Nurses \$230 with annual increases to \$40. 1½ days per mo. cumulative sick leave; 40-hr. wk; 28 days vacation; 10 statutory holidays. Apply: Supt. of Nurses, Trail-Tadanac Hospital, Trail, B.C.

---

**Supt. of Nurses** immediately for 67-bed hospital. Salary open depending on training & experience. **Gen. Duty Nurses** also required. Good salary & personnel policies. New 80-bed hospital opening in 1956. Apply M. M. Barber, R.N., Administrator, Portage Hospital, Dist. No. 18, Portage la Prairie, Manitoba.

---

**Obstetrical Supervisor for 10-bed ward.** Duties to commence July 1. Must have post-graduate training. Residence accommodation. 44-hr. wk. Apply Supt., Miramichi Hospital, Newcastle, N.B.

---

**Night Supervisor & Operating Room Nurse** for 44-bed hospital. Liberal personnel policies. Living accommodation available in new residence. 44-hr. wk., 3-wk. vacation, 8 statutory holidays. For further information apply Supt., Haldimand War Memorial Hospital, Dunnville, Ont.

---

**Operating Room Supervisor, Night Supervisor & Staff Nurses.** Good salary & personnel policies. Living accommodations available. Apply Director of Nurses, General Hospital, Parry Sound, Ontario.

---

**Obstetrical Supervisor (1.) Operating Room Scrub Nurse (1.) General Duty Nurses (3)** for new 144-adult bed plus 32-bassinette hospital. Good salary & personnel policies. Apply Director of Nursing, Plummer Memorial Public Hospital, Sault Ste. Marie, Ontario.

---

**Supervisor (qualified.)** Good salary. Extra allowance for experience if French speaking. 5-day wk., 4-wk. vacation, 18 days sick leave cumulative annually. Car is provided. Half cost of uniform is allowed & half of Blue Cross. Workmen's Compensation. Good working conditions. Apply Sec.-Treas., Porcupine Health Unit, 164 Algonquin Blvd. E., Timmins, Ont.



## EMPLOYMENT OPPORTUNITIES FOR GRADUATE NURSES

Due to the opening of a new wing in a well-equipped, new 125-bed hospital in Sub-urban Toronto. Residence accommodation optional.

### SALARY RANGES

GENERAL DUTY	\$205 - \$275 monthly
HEAD NURSES	\$225 - \$295 monthly
SUPERVISORS	\$240 - \$310 monthly

Enquire:

DIRECTOR OF NURSING, HUMBER MEMORIAL HOSPITAL  
200 CHURCH ST., WESTON, TORONTO, ONTARIO

**Assistant Head Nurses & Staff Nurses** for children's orthopedic hospital. Good personnel policies. Apply Director, Shriner's Hospital for Crippled Children, 1529 Cedar Ave., Montreal, Quebec.

**Registered Nurse (1). Experienced, capable of Matronship for 8-bed hospital.** Salary: \$275 per mo. **Reg'd. Nurse (1).** Salary: \$240 per mo. Must have Sask. Registration. Holidays according to S.R.N.A. 2-wk. sick leave non-cumulative. Maintenance \$30 per mo. Apply Sec., Box 40, Union Hospital, Hodgeville, Sask.

**Matron (1), General Duty Nurse (1) for 20-bed hospital.** Modern nurses' home. Usual holidays with pay & sick leave, etc. Apply stating salary desired to Matron, Union Hospital, Vanguard, Sask.

**Psychiatric Nurse** to assume position as Head Nurse & Clinical Supervisor of new 38-bed Psychiatric Unit in a 500-bed General Hospital. An excellent opportunity for a Psychiatric Nurse who wishes to assume leadership in developing the policies, procedures & teaching program of this new Psychiatric Unit. Patients treated only by psychiatrists. The most modern facilities & treatment methods. Cooperative administration. Bachelor's Degree required plus Psychiatric experience. Salary commensurate with experience & abilities. Write Director of Nursing, Aultman Hospital, Canton, Ohio.

**Science Instructor (1) for Aug. 1. Clinical Instructor (1.)** Good teaching facilities 1 class of approx. 30 students yearly. Good personnel policies. Near enough to Rocky Mountain National Parks for "Days Off." Apply stating qualifications & salary expected to Director of Nursing, St. Michael's Hospital, Lethbridge, Alberta.

**Instructor for School of Nursing to teach Science** — 80 students. New residence. Pension Plan. Good personnel policies. Apply Director of Nursing, Royal Victoria Hospital, Barrie, Ont.

**Instructor for School of Nursing to teach Nursing Arts** — 80 students. New residence. Pension plan. Good personnel policies. Apply Director of Nursing, Royal Victoria Hospital, Barrie, Ont.

**Obstetrical Clinical Instructor (1) & Medical-Surgical Clinical Instructor (1)** for progressive 65-student School of Nursing. Positions available Aug. 1. For further particulars apply Director of Nursing, General Hospital, Belleville, Ont.

**McKellar General Hospital, Fort William, Ont. requires Clinical Instructor** in operating room. Gross salary commensurate with experience, 28 days vacation after 1 yr., 8 statutory holidays, sick leave accumulative to 60 days. Residence accommodation available at reasonable rates. Hospital has recently completed a well equipped & staffed wing with extensive renovation program progressing in the old section. Apply Director of Nursing.

**Nursing Arts Instructor for 220-bed, 41-bassinette hospital** opened Sept. 1953. School of Nursing. Salary scale \$270-\$300 Necessary qualifications essential. Apply Director of Nursing, South Waterloo Memorial Hospital, Galt, Ont.

**Science Instructor for School of Nursing.** Duties to commence August 1st. Apply Director of Nursing, Civic Hospital, Ottawa 3, Ont.

**Nursing Arts Instructor for School of Nursing** — 75 student capacity. Apply stating qualifications & salary expected to Supt. of Nurses, Prince Edward Island Hospital, Charlottetown, P.E.I.



# PEDIATRIC INSTRUCTOR

Responsible for classroom and clinical instruction in pediatric nursing & coordinating maternal & child care program in school where organizational set-up permits stressing of patient-centred care and student-centred learning activities.

*For further information apply:*

**DIRECTOR, SCHOOL OF NURSING, METROPOLITAN GENERAL HOSPITAL, WINDSOR, ONTARIO.**

---

**Clinical Surgical Instructor for 176-bed hospital,** 40 student nurses. Salary: \$265 per mo. 1 mo. vacation per yr, 9 statutory holidays. 41½ hr. wk., off each week-end. For further information apply Director of Nursing, Providence Hospital, Moose Jaw, Sask.

---

**Instructor** for school of nursing — Applications are invited for 138-bed hospital. This school is affiliated with Montreal hospitals, the teaching schools associated with McGill University. For particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

---

**Nursing Arts Instructor, \$400 & Reg'd. Nurses, \$310 per mo.** Retirement plan, sick leave benefits. 3 wk. vacation, 11 holidays, 40-hr. wk. New modern residence. State eligibility for California registration. Submit photograph to Director of Nurses, Tulare-Kings Counties Hospital, Springville, California.

---

**Nursing Arts Instructor** for School of Nursing, with capacity 195 students, attached to expanding hospital of 571 beds. B.S. Degree in Nursing Education preferred or at least 3 yrs. experience & working toward degree. Located in "All American City" of 120,000 in North Eastern Ohio with educational, industrial, recreational & agricultural primary interests. Salary commensurate with qualifications. Write Director of Nursing, Aultman Hospital, Canton, Ohio.

---

**Obstetrical Clinical Instructor** for School of Nursing with capacity 195 students attached to expanding hospital of 571 beds. B.S. Degree in Nursing Education preferred or at least 3 yrs. experience & working towards degree. Located in "all American City" of 120,000 in North Eastern Ohio with educational, industrial, recreational & agricultural primary interests. Salary commensurate with qualifications. Write Director of Nursing, Aultman Hospital, Canton, Ohio.

---

**Registered General Duty Nurses (2) for 76-bed fully modern hospital** on C.P.R. main line & Trans-Canada Highway to Calgary & Banff. Gross salary: \$205 per mo. Perquisites \$30. \$5.00 increment every 6 mo. 8-hr. day, 44-hr. wk. 1 mo. annual vacation with pay. Sick leave with pay. Apply Matron, Municipal Hospital, Brooks, Alta.

---

**Registered General Duty Nurses (3) for 19-bed hospital** in oil town 95 mi. S.W. of Edmonton. Close to Sylvan & Gull Lakes. Daily bus service to Edmonton. Salary: \$200 per mo. plus maintenance & laundry. \$5.00 raise every 6 mo. for 2 yrs. 44-hr. wk. Apply giving full particulars to the Matron, Municipal Hospital, Rimbey, Alta.

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**Registered Nurses (2, experienced)** for 50-bed hospital. Salary: \$185 per mo. plus full maintenance with \$5.00 increases every 6 mo. for 2 yrs. For further information apply Matron Municipal Hospital, Wainwright, Alberta.

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**Registered General Duty Nurses for new 47-bed General Hospital** serving district of 10,000 in friendly town in the Cariboo Dist. B.C. Starting salary: \$225 per mo. \$235 after 6 mo. or B.C. registration 1 mo. vacation, 16 statutory holidays. Transportation allowance. Modern nurses' residence. Board & lodging \$50. Apply Administrator, G. R. Baker Memorial Hospital, Quesnel, B.C.

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**Registered General Duty Nurses for 40-bed General Hospital.** Salary: \$250-\$275 per mo. Annual increments. 40-hr. wk. 4 wk. vacation with pay after 1 yr. 10 statutory holidays. 1½ days sick leave per mo. Apply Sister Superior, St. John Hospital, Vanderhoof, B.C.

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**Registered Nurses (3)** immediately for 36-bed General Hospital in southern Manitoba. Starting salary: \$210 per mo. with 3 wk. vacation with pay 1st yr. employment; 4-wk. vacation thereafter. All statutory holidays. Regular sick leave, 50% Blue Cross payments. Apply Supt. of Nurses, Hospital Dist. No. 24, Box 330, Altona, Manitoba.

## REGISTERED NURSES

**\$2,610-\$3,360**

## CERTIFIED NURSING ASSISTANTS

**\$2,040-\$2,220**

**SUNNYBROOK HOSPITAL  
TORONTO**

**WESTMINSTER HOSPITAL  
LONDON**

Application forms, available at your nearest Civil Service Commission Office, National Employment Service & Post Offices, should be forwarded to the

**CIVIL SERVICE COMMISSION,  
25 ST. CLAIR AVE. E., TORONTO 7, ONTARIO**

**Registered Nurses for new modern 20-bed hospital.** Duties to commence as soon as possible. Salary \$200 per mo. plus maintenance. \$5.00 increase every 6 mo. to maximum of \$220. Good working conditions & living quarters. Holidays after 6 mo. at rate of 2½ days for each mo. of work, maximum 30 days. Apply Memorial Hospital, Deloraine, Man.

**Registered Nurses (2).** Starting salary: \$170 per mo. **Practical Nurse (1).** Starting salary \$115. Two raises of \$5.00 at 6 mo intervals Modern 34-bed hospital. Free maintenance. 3 wk. vacation with pay. Good recreation centre & summer resort. Apply Supt., District Hospital, Souris, Man.

**Registered Nurses (2) for 42-bed General Hospital.** Salary: \$210-\$230 per mo. Excellent accommodation in residence at \$30 per mo. 44-hr. wk. Usual holiday & sick leave benefits. Copy of personnel policy will be mailed upon request. Apply Supt. of Nurses, Bethesda Hospital, Steinbach, Man.

**Registered Nurses.** Single room residence. \$255 per mo. gross. **Central Supply Nurse (1).** 5 day wk. 20 mi. east of Toronto. Apply Supt. Ajax & Pickering General Hospital, Ajax, Ont.

**Registered Nurses.** Gross salary for nurses currently registered in Ont. \$235 per mo. Good personnel policies. New facilities. Comfortable nurses' residence. 8-hr. rotating shift. 44-hr. wk. 1 day off 1 wk., 2 the next. 1½ days holiday allowed per mo. same sick time accumulated to 90 days. 8 legal holidays per yr. The equivalent of single train fare paid up to \$40 after 1 yr. service. Apply Supt., Lady Minto Hospital, Cochrane, Ont.

**Registered General Duty Nurses** for new 58-bed hospital situated in North Western Ontario. Opening about Sept. 1, 1956. Salary: \$215 per mo. subject to increase after 6-mo. with regular annual increase thereafter. \$45 per mo. room & board. 30 days vacation & rail fare refunded after 1 yr. service. New 21-bed nurses' residence, each room having an adjoining bathroom. Apply stating age & when available to Frederick Taylor, Administrator, Dist. General Hospital, Dryden, Ont.

**Registered Nurses.** Minimum salary: \$215 per mo. Maximum salary: \$235 per mo. Good personnel policies. Apply Supt., General Hospital, Espanola, Ont.

**Registered Nurses for General Duty.** Initial salary: \$200 per mo.; with 6 or more months Psychiatric experience, \$210 per mo. Salary increase at end of 1 yr. 44-hr. wk.; 8 statutory holidays, annual vacation with pay. Living accommodation if desired. For further information apply Supt. of Nurses, Homewood Sanitarium, Guelph, Ont.

**Registered Nurses** for 28-bed hospital, 48 mi. southeast of Montreal. Salary \$150 per mo. \$5.00 increment every 6 mo. to maximum \$165 plus full maintenance. 1 mo. annual vacation with pay, all statutory holidays, 2 wk. sick leave, Blue Cross paid. 8-hr. day, rotating shifts. Wonderful summer resort 8 mi. from Lake St. Francis. T.V. in nurses' residence. Apply Mrs. M. G. Curran, County Hospital, Huntingdon, Que.

**Registered Nurses for Supervision & General Duty** in 150-bed Tuberculosis Hospital. 31-day annual vacation, 7 statutory holidays, 44-hr. wk. Three \$5.00 increments every 6 mo. Residence facilities available. Apply stating age, experience & salary expected to Director of Nursing, Grace Dart Hospital, 6085 Sherbrooke St. E., Montreal, Que.

**Reg'd. Nurses for modern 60-bed General Hospital** situated 40 mi. south of Montreal. Salary: \$200 per mo., additional monthly bonus for permanent evening & night shifts. 44-hr. wk., 8-hr. duty. Many attractive benefits provided. Board & accommodation available at minimum cost in completely new motel-style nurses' residence. Apply Supt., Barrie Memorial Hospital, Ormstown, Que.



# CLINICAL INSTRUCTOR IN PEDIATRIC NURSING

Position vacant in July, 1956 in modern well equipped school. Present enrollment 54 students. Gross minimum salary: \$3,302 per yr. 5-day week. 28-days vacation after 1 yr. 9 statutory holidays.

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**PERSONNEL DIRECTOR, GENERAL HOSPITAL, SARNIA, ONTARIO**

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**Registered Nurses (1 or 2)** for 24-bed hospital. Salary: \$190 per mo. Full maintenance. Usual increases after 6 mo. Holidays, sick leave. Modern nurses' home. Apply Matron, Union Hospital, Vanguard, Saskatchewan.

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**Registered Nurses for General Duty Staff.** Salary commences at £40-10-0 per mo. with full maintenance. Transportation allowance. For full particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

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**Registered Nurses. Male & Female.** Starting salary: \$300 up, plus \$10 pm shifts. 40-hr. wk., paid vacation, 10 days sick leave. Social Security, hospital group ins. Apply Mr. Glenn A. Dickau, R.N., Administrator, Memorial Hospital, Corning, California.

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**Registered General Duty Nurses for 118-bed General Hospital** along the shores of Lake Michigan, 25 mi. from Chicago. Base salary: \$300. Additional differential of \$30 for evenings & \$20 for nights. 5 day wk. Good personnel policies. Apply Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

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**Registered Staff Nurses,** immediate appointments, in 511-bed newly enlarged and finely equipped general hospital. Duty assignments in medical, surgical, pediatrics, psychiatric, obstetrics, or contagion units. Northeastern Ohio stable "All-American City" of 120,000. In centre of area of recreational, industrial, and educational friendly activities. Living costs reasonable. Within pleasant driving-distance advantages of metropolitan Cleveland and Columbus, Ohio and Pittsburg, Pa. Friendly, cooperative work relations and conditions. Progressively advanced personnel policies. Starting salary: \$240 per mo. with 4 merit increases. Paid vacation, sick leave, recognized holidays, premium pay, sickness insurance and hospitalization program, retirement. Contact: Director of Personnel, Aultman Hospital, Canton, Ohio, by letter or collect telephone 4-5673.

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**Registered Nurses for 284-bed General Hospital** with vacancies in most departments including Psychiatry. Opportunity for advancement. Located on the beautiful Corpus Christi Bay in Texas which is a pleasant tropical climate. Positions available for (1) **Supervisors,** salary: \$280-\$315 per mo. (2) **General Staff,** starting salary: \$250-\$275 according to experience plus \$10 differential for evening or night shifts. Liberal personnel policies, 40-hr. wk. & \$50 transportation allowance. Apply Director of Nursing Service, Memorial Hospital, P.O. Box 5008, Corpus Christi, Texas.

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**General Duty Nurses for Maternity Service** in new 100-bed Maternity Hospital. Active case room service with an average of 400 deliveries monthly. Salary scale: \$200-\$220 per mo. plus meals & laundry with opportunity for promotion. Apply Director of Nursing Service, Alexandra Hospital, Edmonton, Alta.

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**General Duty Nurses (3) for 31-adult bed hospital.** Salary: \$195 less \$20 perquisites. Increase of \$10 after each 6 mo. Full maintenance, separate nurses' residence. 2-wk. vacation plus 2-wk. in lieu of statutory holidays with pay after 1 yr. service. 8-hr. shifts, 48-hr. wk. Apply Matron, Municipal Hospital #19, Vulcan, Alta.

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**General Duty Nurses** for 110-bed General Hospital situated in the beautiful Fraser Valley, 68 mi. from Vancouver. Good bus service. Salary: \$230 per mo. Personnel policies in accordance with R.N.A.B.C. agreement. 40-hr. wk. Residence accommodation. Apply Director of Nursing, General Hospital, Chilliwack, B.C.

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**General Duty Nurses for active 18-bed hospital,** 10 mi. from Radium Hot Springs. New modern hospital & separate nurses' residence to be completed July. Salary: \$235 per mo. Personnel policies in accordance with R.N.A.B.C. 40-hr. wk. Apply Supt. of Nurses, Bruce Memorial Hospital, Invermere, B.C.



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**Why Unique?** Only English speaking hospital & training school in Quebec City

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**General Duty Nurses.** Salary: \$230-270, \$10 increment for experience. 40-hr. wk. 1½ days sick leave per mo. cumulative; 10 statutory holidays, (1) mo. vacation. Must be eligible for B.C. registration. Apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

**General Duty Nurses (3) for 27-bed Community Hospital by middle of June.** Salary: \$230 per mo. with annual increments of \$5.00 per mo. 40-hr. wk. 28 days vacation after 1 yr. service. All statutory holidays paid. Room, board & laundry \$40 per mo. Apply, giving full details, Matron, Slocan Community Hospital, New Denver, B.C.

**General Duty Nurses** for 430-bed hospital; 40-hr. wk. Statutory holidays. Salary: \$235-268. Credit for past experience. Annual increments; cumulative sick leave; 28 days annual vacation; B.C. registration required. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

**Royal Jubilee Hospital, Victoria, B.C.** invites applications for **General Duty Nurses** for permanent positions & vacation relief in 500-bed General Hospital. Salary \$227.50-\$262.50. 5-day, 40-hr. wk. 4-wk. vacation. 10 statutory holidays. Pension plan. Attractive employee benefits. Apply, Director of Nursing.

**General Duty Nurses (2) for new 42-bed hospital on sea coast, 25 mi. south of Vancouver.** Salary: \$220 for non-B.C. Registered. 40-hr. wk., 28 days annual vacation, 10 statutory holidays. Accumulated sick leave. Apply Director of Nursing, White Rock District Hospital, White Rock, B.C.

**General Duty Nurses for 30-bed Morris General Hospital & 10-bed Emerson Hospital.** Both hospitals located just south of Winnipeg on Highway #75 are new & well equipped. Salary: \$220 per mo. \$35 per mo. full maintenance including laundering of uniforms. \$5.00 extra every 2 wks. of night duty. 4 wk. vacation. All recognized statutory holidays. Sick leave cumulative to 30 days. 50% off Blue Cross premiums. Apply J. G. Friesen, Morris Hospital Dist. #25, Morris, Man.

**General Duty Nurse for Surgical Unit** handling thoracic & orthopedic surgery. For further information please apply Director of Nursing, Fort William Sanatorium, Fort William, Ont.

**General Duty Nurses** for well equipped 47-bed hospital. 8-hr. duty, 5½ day wk. Annual vacation with pay, statutory holidays. Full maintenance in new modern residence. For further information apply Supt., General Hospital, Kincardine, Ont.

**General Duty Nurses for Medical, Surgical, Pediatrics, Obstetrics.** Good salary & personnel policies. Apply Director of Nursing, Victoria Hospital, London, Ont.

**General Duty Nurses** for all departments. Gross salary: \$210 per mo. if registered in Ontario \$200 per mo. until registration has been established. \$20 per mo. bonus for evening or night duty; annual increment of \$10 per mo. for 3 yrs. 44-hr. wk., 8 statutory holidays, 21 days vacation & 14 days leave for illness with pay after 1 yr. of employment. Apply: Director of Nursing, General Hospital, Oshawa, Ont.

**General Staff Nurses (immediately) for operating room.** Apply Director of Nursing, Civic Hospital, Ottawa 3, Ont.

**General Duty Nurses** for modern 42-bed hospital. Excellent equipment & facilities. Starting salary: \$225 per mo. Annual increments. Good personnel policies. Apply Supt. of Nurses, General Hospital, Sioux Lookout, Ont.

**General Duty Nurses (2) for well equipped small hospital for permanent staff or summer relief.** Salary: \$175 plus full maintenance. 8-hr. duty 5½ day wk. rotating shifts, long week-end following night duty. Blue Cross. Popular summer resort. Apply Supt., Saugeen Memorial Hospital, Southampton, Ont.

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**NEW 300-BED GENERAL HOSPITAL**

**INITIAL SALARY: \$225 PER MONTH, PLUS LAUNDRY**

**EXCELLENT PERSONNEL POLICIES**

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**Graduate Nurse** interested in the rehabilitation of the handicapped to direct care in ward of 20-wheelchair children. Apply Supt., Home for Incurable Children, 278 Bloor St. E., Toronto, Ont.

**General Duty Nurses (4)** for modern active 45-bed hospital. Busy town of 2,500. Daily bus to N. Battleford & Saskatoon. Basic salary: \$225 per mo. less \$30 per mo. for maintenance. 8-hr. rotating shift. Separate nurses' residence. Transportation by bus or rail up to an amount of \$50 allowed after 1 yr. service. Apply stating age & experience to Matron, Union Hospital, Meadow Lake, Sask.

**General Duty Nurses (3)** on or after June 15/56 for new modern 23-bed hospital of one floor construction. Population of town 1,500. 50 mi. from the city of Prince Albert & Saskatoon with excellent train & bus connections. Gross salary: \$230 per mo. with 6 increments of \$5.00 each 6 mo. less maintenance of \$30 per mo. Apply stating qualifications & experience to J. L. Fawcett, Sec.-Man., Union Hospital, Rosthern, Sask.

**General Staff Nurses** for 400-bed Medical & Surgical Sanatorium, fully approved student affiliation & postgraduate program. Full maintenance. Recreational facilities. Vacation with pay. Sick benefits after 1 yr. Blue Cross coverage. Attractive salary; 40-hr. wk. For further particulars apply Supt. of Nurses, Nova Scotia Sanatorium, Kentville, N.S.

**Staff Nurses** for 600-bed General & Tuberculosis Hospitals with School of Nursing. Salary: \$288-\$341. Shift, special service & educational differentials, \$10. 40-hr. wk; 3-wk. vacation; 11 holidays; accumulative sick leave. Apply Associate Director of Nursing Service, County General Hospital, Fresno, California.

**General Duty Nurses** for 650-bed teaching hospital in central California. Salary: \$288-\$337 per mo. 40-hr. wk. Liberal vacation, holiday & sick leave plan. Apply Personnel Office, 510 E. Market St., Stockton, California.

**Nurses for Florida Tuberculosis Hospital.** Rapidly developing program with abundant opportunities for advancement. Beautiful hospital, new & attractive quarters if desired. Salary dependent on qualifications. Liberal retirement & other benefits. 40-hr. wk. Apply Director of Nursing, Southeast Florida Tuberculosis Hospital, P.O. Box 1411, Lantana, Florida.

**General Duty Staff Nurses** for modern 250-bed hospital. All departments. Near all New York Universities. 40-hr. wk. Excellent salary, bonus 4-12 & 12-8 shifts, regular increments. Single room in nurses' residence at low rates. Apply Director of Nurses, Lebanon Hospital, Mt. Eden Ave. & Grand Concourse, New York 57, N.Y.

**Staff Nurses & Operating Room Scrub Nurses** for 225-bed General Hospital on outskirts of New York City. Salary \$240-\$280; \$20 extra for O.R. duty; \$30 for permanent evening duty; \$25 for permanent night duty. Apply Director of Nursing, St. John's Riverside Hospital, Yonkers, N.Y.

**Graduate Nurses (3)** for 24-bed hospital. Salary: \$230 per mo. if B.C. registered; less \$40 board, lodging, laundry. 1 mo. vacation after 1 yr. on full pay. 1½ days sick leave per mo. cumulative. Apply, stating experience to Matron, Terrace & District Hospital, Terrace, British Columbia.

**Graduate Nurses (General Staff Positions)** for General Hospital. Salary: \$235.50 per mo. as minimum & \$273.75 as maximum, plus shift differential for evening & night duty. 40-hr. wk. Temporary residence accommodation is available. Applicants not registered in B.C. should forward a letter of acceptance of registration in B.C. from the Registrar of Nurses, 2524 Cypress St., Vancouver, B.C. Please apply Personnel Dept., Vancouver General Hospital, Vancouver, B.C.



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- Vacation with pay.
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Victorian Order of Nurses for Canada,  
193 Sparks Street, Ottawa 4, Ont.**

**Graduate Nurses & Dietician (1)** for new, very modern 88-bed hospital in a pleasant progressive town. Nurses salary: \$200 per mo. Annual increase \$10 per mo. for 3 yrs. 2-wk. shift rotation, bonus for night shifts. 1 hr. drive to Toronto & several resorts. Local swimming pool, bowling alleys, skating, theatres etc. Apply Director of Nurses, Dufferin Area Hospital, Orangeville, Ont.

**Graduate Nurses (2)** immediately for new fully modern 16-bed hospital. Salary: \$230 per mo., \$25 deducted for full maintenance. Additional \$180 plus 1 mo. vacation after 12 mo. continuous service. New modern nurses' residence. Apply Matron, Union Hospital, Maidstone, Sask.

**Operating Room Nurses (2), Registered Nurses & Certified Nursing Assistants for general duty.** 44-hr. wk. Statutory holidays. Annual vacation with pay. For further information apply Supt. of Nurses, General Hospital, Cobourg, Ont.

**Operating Room Nurse, postgraduate training not essential.** All graduate staff. A.N.P.Q. salary scale in effect. 8-hr. day, 5½ day wk. Apply Director of Nursing, Montreal Children's Hospital, Montreal, Que.

**Operating Room Nurses,** immediate appointments, for 511-bed newly enlarged and finely equipped hospital; 10 operating rooms now completed. Northeastern Ohio stable "All-American City" of 120,000. In centre of area of recreational, industrial and educational friendly activities; living cost reasonable. Within pleasant driving-distance advantages of metropolitan Cleveland and Columbus, Ohio, and Pittsburg, Pa. Friendly and considerate working associates and conditions. Progressively advanced personnel policies. Starting salary: \$240 per mo. with 4 merit increases. Paid vacation, sick leave, recognized holidays, premium pay, sickness insurance and hospitalization program, retirement. Contact Director of Personnel, Aultman Hospital, Canton, Ohio, by letter or collect telephone 4-5673.

**Operating Room Nurse for modern air-conditioned, 6-room suite, 230-bed hospital.** Starting salary: \$300 per mo., automatic increases. 40-hr. wk. Apply Mrs. H. E. Sylvester, Victory Memorial Hospital, Waukegan, Illinois.

**Baker Memorial Sanatorium, Calgary, Alberta,** offers to Graduate Nurses a 6-mo. post-graduate course in Tuberculosis. Maintenance & salary as for general staff nurses. Opportunity for permanent employment if desired. Spring & Fall Classes. Further information on request.

**Supervisor (1), Public Health Staff Nurses (2) for generalized program** in city of 43,000. Blue Cross & P.S.I. employer shared. Transferrable accumulative sick leave & pension plans. Workmen's Compensation. Group ins. available. Transportation provided or allowance — 10¢ first 2,000 mi., 8¢ per mi. thereafter. 5-day wk. 1 mo. vacation with extra time at Christmas. Salary scales: (1) Supervisors, \$3,600-\$4,400 with annual increment of \$200. (2) Field Nurses, \$3,000 for inexperienced nurses to start with annual increments of \$150. All starting salaries dependent on experience. For further information please write supplying details of training & experience to Medical Officer of Health, City Hall, Peterborough, Ont.

**Public Health Nurse (1) fully qualified with some experience.** Duties to commence July 1, 1956. Salary & conditions as recommended by R.N.A.O. Apply B.C. Falby, Sec., Board of Health, Box 9, Ajax, Ont.

**Public Health Nurses for generalized program** in rural-suburban Health Unit near Toronto. Minimum salary: \$3,000. Pension plan. For full details apply Supervisor, Peel County Health Unit, Court House, Brampton, Ont.



# INSTRUCTOR

**Required before Sept. 1st, 1956**

**Prerequisite 1-year course in Nursing Education**

Allowance made for degree if experienced. Student enrollment approximately 75. 1 class per year enters in September. Teaching staff of Director of Nursing Education & 4 Instructors. New school & residence to be ready for occupancy in 1957. Guelph is a pleasant city of 38,000. 3 Colleges. Good salary & personnel policies.

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**Public Health Nurse Grade 1.** British Columbia Civil Service, Dept. of Health & Welfare. Starting Salary \$255, \$260, \$266 per mo., depending on experience, rising to \$298. per mo. Promotional opportunities available. Qualifications: Candidate must be eligible for registration in British Columbia & have completed a University degree or Certificate course in Public Health Nursing. (Successful candidates may be required to serve in any part of the Province.) Cars are provided. 5-day wk. in most districts. Uniform allowance. Candidates must be British subjects; preference is given to ex-service women. Application forms obtainable from all Government Agencies, the Civil Service Commission, 544 Michigan St., Victoria, or 411 Dunsmuir St., Vancouver 3, to be completed & returned to the Chairman, Civil Service Commission, Victoria. Further information may be obtained from the Director, Public Health Nursing, Dept. of Health & Welfare, Parliament Bldgs., Victoria, B.C.

**Public Health Nurse for Town of Deep River.** Salary: \$3,005 to \$3,395 depending on qualifications. Pension, medical & vacation plans. Living accommodation in staff hotel. State all particulars including age, marital status, education & experience in first letter to "File 2A", Atomic Energy of Can. Ltd., Chalk River, Ontario.

**Public Health Nurses (qualified) for generalized program.** Salary \$2,700 to \$3,200 depending on experience. Annual increment \$100. 5-day wk. Pension plan. Blue Cross & P.S.I. available. Car provided or car allowance. Apply Dr. Charlotte M. Horner, Director, Northumberland-Durham Health Unit, Cobourg, Ont.

**Public Health Nurses — Generalized program.** Minimum salary: \$2,800 with allowance for experience & annual increments. Generous provision for transportation. For further details write Dr. R. M. Aldis, Director Huron County Health Unit, Goderich, Ont.

**Public Health Nurses (qualified) for generalized health service program.** 5-day wk. 1 mo. vacation. Pension plan. Medical & surgical Blue Cross. Apply Dr. A. F. Bull, Medical Officer of Health, Drawer 307, Milton, Ont.

**Public Health Nurses** for generalized program, bedside nursing included. Rural area. Blue Cross & group ins. available. Good transportation policy. 4-wk. vacation after 1 yr., statutory holidays. Apply Dr. J. I. Jeffs, Lennox & Addington County Health Unit, Napanee, Ont.

**Public Health Nurse (1) for generalized program** in rural & semi-urban area adjacent to metropolitan Toronto. Excellent working conditions including pension plan, group ins. & transportation arrangements. Apply Dr. R. M. King, York County Health Unit, Newmarket, Ont.

**Public Health Nurses (qualified)** for generalized program in urban area. Starting salary: \$2,900-\$3,200 depending on experience. Annual increment \$150. Transportation provided. 5-day wk. Pension Plan. Hospitalization & sickness insurance available. Apply A. F. Mackay, Board of Health, City of Oshawa, Ont.

**Public Health Instructor (1). Pediatric Instructor (1) for 50-student School of Nursing.** 1 class per yr. Personnel policies based on R.N.A.O. recommendations. For full details apply Director of Nursing, General Hospital, Port Arthur, Ont.

**Public Health Nurses (qualified.)** Salary: \$3,100 depending on dist. served, less if in the Timmins area. Annual increment \$150 per annum for 4 yrs. Additional allowance for experience & if French-speaking. 5-day wk. 4-wk. vacation, 18 days sick leave annually (cumulative.) Car is provided. Half cost of uniform is allowed & half of Blue Cross. Workmen's Compensation. Good working conditions. Apply Sec.-Treas., Porcupine Health Unit, 164 Algonquin Blvd. E., Timmins, Ont.

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for

200-bed hospital

Pleasant city of 38,000. Three colleges.

Good salary and personnel policy.

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**Registered Laboratory Technician (Immediately) for 56-bed hospital** with knowledge of X-Ray preferably. Pleasant working conditions. Apply Mrs. A. Kerby, R.N., Supt., Municipal Hospital Dist. #20, Stettler, Alta.

**Assistant Office Nurse for Wainwright Clinic.** Please state qualifications & salary expected. Apply Wainwright Clinic, Wainwright, Alberta.

**Matron & Graduate Nurses (2) for new model 7-bed hospital** in South Central Saskatchewan. Salaries: \$260 & \$225 with \$5.00 increment every 6 mo. \$30 maintenance per mo. 3 wk. vacation & statutory holidays. Uniforms laundered free. Sick leave. Apply Matron, Union Hospital, Rockglen, Sask.

**Registered General Duty Nurse for new modern hospital close to city of Saskatoon.** Gross salary: \$230, perquisites \$30 per mo. with \$5.00 increment every 6 mo. 8-hr. day. 1 mo. holiday with pay after 1 yr. service. Apply Matron, Union Hospital, Eston, Sask.

**Public Health Nurses (Qualified) for generalized Public Health Nursing Service.** Salary range: \$3,186-\$3,618. Starting salary based on experience. Annual increments. 5-day wk. Vacation. Sick pay & pension plan benefits. Apply Personnel Dept., Room #320, City Hall, Toronto, Ont.

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ARVIDA, QUEBEC

requires

General Duty Nurses registered in  
Province of Quebec.

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OPERATING ROOM SUPERVISOR

Previous experience in operating room supervision essential. Starting salary commensurate with qualifications & experience. Regular employment. Very favorable working & living conditions. Room, board & laundering of uniforms provided.

For further information please write stating qualifications & experience to:

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**Nursing Arts Instructor** for progressive School of Nursing. Student enrollment 65. Liberal personnel policies. Apply Director of Nursing, General Hospital, Belleville, Ontario.

**Registered Nurses (2).** Duties to commence as soon as possible. For further information apply O. M. Nicholson, Secretary, Municipal Hospital, Fairview, Alta.

**Public Health Nurses.** Duties to commence between June & Sept. 1956. Salary: \$2,796-\$3,396. 5-day wk. 1 mo. vacation. Pension plan. Apply Dr. W. H. Hill, M.O.H., Dept. of Health, Calgary, Alta.

**Registered General Staff Nurses (5)** for 75-bed General Hospital. Starting salary: \$245. Increases every 6 mo. Full maintenance \$30. 44-hr. wk. Apply Supt., St. Thérèse Hospital, Tisdale, Sask.

**Supervisor Public Health Nursing**—Well established generalized program. Basic staff of 8 nurses. Car allowance. Retirement contributions & other fringe benefits. Apply Dr. R. M. Aldis, Director, Huron County Health Unit, Goderich, Ont.



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Applications are invited from Registered Nurses with previous experience in operating room supervision. Salary open. Good personnel policies.

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**DR. E. WILSON, SUPERINTENDENT**

**Instructor for student affiliation program in 165-bed Sanatorium.** Apply Supt., Niagara Peninsula Sanatorium, St. Catharines, Ontario.

**Registered Nurses for psychiatry.** Student affiliation or postgraduate work preferred. For information write Director of Nursing, Victoria Hospital, London, Ontario.

**Registered Nurses for new 65-bed hospital,** 25 mi. north of Winnipeg. Hourly bus service. Salary: \$195-215. \$10 differential for evening & night duty. Accommodation available in new residence with T.V. Usual personnel policies. Apply Supt. General Hospital, Selkirk, Manitoba.

**Public Health Nurses, Generalized Program.** Minimum salary: \$2,840. Allowance for experience & annual increments. 5-day wk. 4-wk. vacation after 1 yr. Pension plan, Blue Cross & Windsor Medical Services available. For further details apply W. H. Johnston, M.D., Medical Officer of Health, City Hall, Chatham, Ontario.

**Public Health Nurse (Qualified) for Haldimand County, School Health Service.** University certificate in Public Health Nursing required. State qualifications, experience & salary expected. Apply E. B. McPherson, Lowbanks, Ont., telephone, Wainfleet 104 R-3.

**Registered Laboratory Technician for 35-bed hospital.** State qualifications. Apply Supt. of Nurses, Memorial Hospital, Mission City, British Columbia.

**Nurse Secretary or Stenographer with partial nurse's training required in August for position as secretary in Montreal doctor's office.** An alert person, able & willing to take responsibility. Will find this pleasant, interesting & well-paid work. Reply giving qualifications to Box G, The Canadian Nurse Journal, 1522 Sherbrooke St., W., Montreal 25, Que.

**Superintendent of Nurses for 30-bed General Hospital.** Salary: \$300 per mo. rising to \$330 per mo. State previous experience. Residence accommodation. Apply Administrator, General Hospital, Ladysmith, B.C.

**Assistant Evening & Night Supervisor for 115-bed hospital with school of nursing.** Moving to new hospital at end of year. Apply Director of Nursing, Children's Hospital, Winnipeg, Man.

**Science Instructor for August 1st.** 1 class yearly, approx. 25 students. Apply Director of Nursing, Children's Hospital, Winnipeg, Man.

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# Official Directory

## Provincial Associations of Registered Nurses

### ALBERTA

#### Alberta Association of Registered Nurses

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## QUEBEC

### The Association of Nurses of the Province of Quebec

The Association of Nurses of the Province of Quebec, created by Licensing Act, April 17, 1946, replacing The Registered Nurses Association of the Province of Quebec  
Incorporated February 14, 1920.

Pres., Mlle Eve M. Merleau, 3201 ave Forest Hill, Montréal 26; Vice-Pres. (Eng.), Miss H. Lamont, Sr. M. Felicitas; (Fr.), Sr. Marie-Paul, Mlle A. Mailloux; Hon. Sec., Sr. Jeanne Forest; Hon. Treas., Miss E. Geiger; Councillors, Mlles R. Aubin (Dist. 3), I. Frédette (Dist. 4), S. Pilon (Dist. 6), M. Gauthier (Dist. 8), F. Verret (Dist. 9). The above constitute the Executive Council and are Members of the Committee of Management, together with: Mlles C. Samson, R. Dussault, G. Lamarre, M. Jalbert, L. Couet, G. Badeaux, G. Côté, Misses M. Ferguson, M. Holder, A. Christie, Sr. Ste-Sophie Barat. *Advisory Committee*, Misses R. Chittick, C. Aitkenhead, E.

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### District 11

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## SASKATCHEWAN

### Saskatchewan Registered Nurses' Association (Incorporated 1917)

Pres., Miss Mary T. Mackenzie, St. Paul's Hosp., Saskatoon; Vice-Pres., Miss L. Miner, Prov. Dept. of Public Health, Prov. Health Bldg., Regina; Sr. Rosario, Holy Family Hosp., Prince Albert; Councillor, Mrs. A. Greening, Holy Family Hosp., Prince Albert. *Committees:* Institutional Nursing, Miss P. McGrath, 18 Newell Apt., Regina; Public Health Nursing, Miss I. Langstaff, 35 Kewatin Apt., Saskatoon; Private Nursing, Miss E. Robinson, Ste. 6, Grenfell Apt., Regina; Asst. Registrar, Mrs. E. Donnelly; Exec. Sec.-Registrar, Miss Lola Wilson, 401 Northern Crown Bldg., Regina.



# Alumnae Associations

## ALBERTA

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### Grace Hospital, Winnipeg

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### Misericordia Hospital, Winnipeg

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## *L'Infirmière Canadienne*

VOLUME 52

NUMBER 7

JULY 1956

- 510** NEW PRODUCTS
- 517** IN TIME OF NEED
- 519** CONFUSING NOTIONS OF MENTAL HEALTH.....*A. B. Stokes*
- 524** IMPACT OF CHRONIC ILLNESS.....*E. C. Phillips*
- 530** LIFE, PROFESSION AND SCHOOL.....*Sir F. Clarke*
- 534** EPIDERMOID CARCINOMA.....*L. Watanabe*
- 537** SALT-LOSING NEPHRITIS.....*D. Richards and R. Dodkin*
- 539** SCHIZOPHRÉNIE ..... *Sr. Louis-Etienne*
- 543** NURSING PROFILES
- 545** IN MEMORIAM
- 546** SÉLECTION
- 548** NURSING ACROSS THE NATION
- 552** LE NURSING À TRAVERS LE PAYS
- 556** BOOK REVIEWS
- 557** NEWS NOTES
- 574** EMPLOYMENT OPPORTUNITIES

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THROUGH THE YEARS many superlatively good addresses have been published in *The Canadian Nurse* that are practically timeless, so far as their appropriateness is concerned. This splendid material is only uncovered occasionally by postgraduate students doing thesis work. It is our plan to reproduce some of these articles from time to time so that a new generation of nurses may profit by reading them.

The first such reprint is the excellent article by **Sir Fred Clarke** that was published in our August, 1932 issue. At the time he delivered the address to the biennial convention at Saint John, N.B., Dr. Clarke was professor of education at McGill University, Montreal. Later, he returned to England as director of the Institute of Education, University of London. He was knighted before his death.

In reading this article, bear in mind that the survey of nursing in Canada, conducted by Dr. George Weir, was a newly accomplished guide to future developments. Dr. Clarke was very aware of it as he prepared his address.

\* \* \*

As we edited the article on salt-losing nephritis for publication we made some enquiries locally regarding the incidence of this unusual condition. Our internist informant told us it is a very rare condition — he had not seen a patient with this disease during his practice. The fact that it occurs very seldom is reflected in the almost complete absence of reference to it in textbooks and certainly warranted its inclusion here.

\* \* \*

As a participant in the specially arranged course at Canadian Civil Defence College, Arnprior, **Miss Jean MacGregor** was very much impressed by the realistic appearance of the wounds grease paint and plasticine produced in otherwise healthy-appearing individuals. The handbook to which she refers gives clear and concise instructions regarding the preparation of a wide variety of casualty simulations. It should prove a clever and useful adjunct for nursing instructors. But don't leave the book around casually for possible investigation by non-nursing colleagues or they may put on a demonstra-

tion of an aspect of casualty simulation — without benefit of grease paint!

\* \* \*

In response to numerous requests for information, we have been assured by Mr. Robin Strachan, manager of the college-medical books department, of the Macmillan Company of Canada Limited that they are "very much in business." Books published by The Macmillan Company of New York may be procured from Hollinger House, 25 Hollinger Road, Toronto 16. The Macmillan Company of Canada can be reached at their usual address, 70 Bond St., Toronto 2. Be sure to look on the fly-leaf to find which division has published the particular book you want to order.

\* \* \*

Those of you who were reading *The Canadian Nurse* in September 1949 will remember the excellent summary of clinical laboratory procedures that **Dr. E. M. Watson** had prepared for us. Or, perhaps you remember referring to them in reprint form during your undergraduate days for over 7,000 such reprints were sold.

We are delighted that Dr. Watson's completely revised material will be available in next month's issue. We anticipate that there may be a demand for reprints again though at the time of writing this we have no estimate of what the price might be. We are including a half-page order form in this issue so that instructors who wish them for their classes, and individual nurses, may be ready, as soon as the August issue is received, to send off their order for copies.

\* \* \*

Last March, the School of Nursing of Dalhousie University sponsored an exceedingly interesting and well attended institute on the Nursing Aspects in Rehabilitation and Care of the Chronically Ill. The principal speaker was **Miss Elisabeth Phillips** of Rochester, N.Y., who delivered four pertinent papers and participated most actively in the ensuing discussion. All of these papers will be reproduced in consecutive issues. They would make an excellent basis for group discussions at chapter meetings next fall.

---

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VANCOUVER 8, BRITISH COLUMBIA.**



# New Products

Edited by DEAN F. N. HUGHES

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## CONVENIL

**Manufacturer**—Fidelity Pharmaceutical Co. Ltd., Toronto, under license to Haemato-gen Hommel Ltd., Zurich, Switzerland.

**Description**—Each dragee contains: Phenylethylacetic acid-B-diethylaminoethylester citrate 75 mg., extract of ergot total alkaloid as ergotamine 0.1 mg., extract of belladonna total alkaloid as hyoscyamine 0.1 mg.

**Indications**—Generally in hyperexcitability of the autonomic nervous system; neuroses with spasm, i.e., all gastrointestinal types including spastic constipation; hypermotility in peptic ulcer; spastic dysmenorrhea and menopausal disturbance; thyrotoxic climacteric and chronic alcoholic neuroses; irritability and hypersensitivity.

**Administration**—Adults: average 1 dragee 3 to 4 times daily; in special cases up to 6 dragees daily.

Children: 1 dragee 1 to 3 times daily, according to age.

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## CEREVON TABLETS, ELIXIR

**Manufacturer**—Calmic Limited, 309-310 Terminal Bldg., York St., Toronto, Ont.

**Description**—Each tablet or 1 fluid dram of elixir contains 150 mg. ferrous succinate, providing 35 mg. ferrous iron, nonirritant to stomach, with a high utilization coefficient.

**Indications**—Iron-deficiency anemias.

**Administration**—Adults, one tablet or one fl. dr. t.i.d. or as prescribed. Children's dosages vary according to age.

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## DEXO-HIST

**Manufacturer**—Paul Maney Laboratories, Hamilton, Ont.

**Description**—Each 1 cc. contains: Pyranisamine maleate 30 mg., dextro-amphetamine HCl 3 mg., phenol 0.5%, injection water q.s.

**Indications**—For use in antihistamine therapy.

**Administration**—1 cc. daily or as determined by the physician, intramuscularly.

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## I. D. M.

**Manufacturer**—Rougier Inc., Montreal.

**Description**—Each tablet contains: Potassium iodide 325 mg., dihydroxypropyl theophylline 200 mg., mepyramine maleate 25 mg.

**Indications**—Bronchial asthma.

**Administration**—One tablet as prescribed.

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## MEDOMIN

**Manufacturer**—Geigy Pharmaceuticals, Montreal.

**Description**—Cycloheptenylethyl barbituric acid (brand of heptabarbital). In low dosage, it exercises a mild sedative action for daytime relief of anxiety and tension. In larger doses, it produces hypnotic action of medium duration.

**Indications**—Insomnia of functional origin; anxiety-tension states where a daytime tranquilizing effect is desired.

**Administration**—The customary hypnotic dosage in adults is 200-400 mg., one hour before retiring. For sedative purposes the average dosage is 50-100 mg. 2 or 3 times daily.

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## MEPHENESIN

**Manufacturer**—Paul Maney Laboratories of Canada Ltd., Hamilton, Ont.

**Description**—Each white scored tablet contains mephenesin 500 mg.

**Indications**—As a muscle relaxant in muscle spasm or rigidity; anxiety states.

**Administration**—Orally 1 or 2 tablets 1 to 5 times daily as prescribed.

---

## MESTINON

**Manufacturer**—Hoffman-La Roche Limited, Montreal.

**Description**—The active substance of mestinon (pyridostigmin bromide) belongs to the physostigmin group. It stimulates cholinergic nerves and motor endplates by inhibiting cholinesterase. Represents an advantage over prostigmin as it has a markedly smoother and more prolonged action, and a more even maintenance of effect. Lacks muscarinic and nicotinic side reactions.

**Indications**—All conditions requiring stimulation of transmission of nervous impulses at cholinergic synapses and excitation of motor endplates, particularly myasthenia gravis. In those patients who cannot tolerate prostigmin without atropine, mestinon is the drug of choice. Latest clinical reports indicate that in some cases a combination of mestinon and prostigmin is of the greatest benefit.

**Administration**—One or two tablets 3 times daily or more as required. Dose should be adjusted to patient's response.

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*The Journal presents pharmaceuticals for information. Nurses understand that only a physician may prescribe.*



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### 1956-1957

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*For additional information, write to:*

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McMaster University, Hamilton, Ontario.**

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#### MERATRAN with RESERPINE

**Manufacturer**—The Wm. S. Merrell Company, St. Thomas, Ont.

**Description**—Each tablet contains: Meratran (pipradrol) HCl 1.0 mg., reserpine 0.25 mg.

**Indications**—For the treatment of emotional problems characterized by the mixed clinical picture of depression with tension.

**Administration**—One tablet 3 times daily. Individual response will determine optimal dosage. Because of the latent period before reserpine exerts its activity, medication should be continued for about one week before increasing dosage above 3 tablets daily.

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#### PAYNOCIL

**Manufacturer**—C. L. Bencard, Weston, Ont.

**Description**—Each scored tablet contains: Acetylsalicylic acid 10 gr., aminoacetic acid 5 gr.

**Indications**—Provides the analgesic effects of A.S.A. in nonirritant, palatable form suitable for massive dosage and prolonged administration.

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#### TRONOLEN LOTION

**Manufacturer**—Abbott Laboratories Ltd., Montreal.

**Description**—Tronothane HCl 1%, di-paralene HCl 2%, with prepared calamine, zinc oxide, and menthol in a flesh-toned emollient base.

**Indications**—For topical application in the relief of surface pain or itching in various dermatoses, pruritus, minor burns or sunburn, poison ivy, oak or sumac, insect bites, athlete's foot, abrasions, chafing.

**Administration**—Apply 3 or 4 times daily. Prolonged use of application to extensive areas of body is not recommended.

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#### VOYAGOL

**Manufacturer**—Paul Maney Laboratories, Hamilton, Ont.

**Description**—Each tablet contains: Sodium bromide 5 gr., scopolamine hydrobromide 1/250 gr., thiamine hydrochloride (B<sub>1</sub>) 3 mg., pyridoxine hydrochloride (B<sub>6</sub>) 3 mg., pyridoxine hydrochloride (B<sub>6</sub>) 3 mg.

**Indications**—Relieves nervousness, insomnia, sea sickness, air sickness, car sickness and train sickness.

**Administration**—One tablet 3 times daily, or as prescribed.

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**Director, McGill School for Graduate Nurses,  
1266 Pine Ave. W., Montreal 25, Que.**

### AMYOTENSIN

**Manufacturer**—Paul Maney Laboratories of Canada Ltd., Hamilton, Ont.

**Description**—Hyoscyamine hydrobromide 1/150 gr., phenobarbital sodium 1 gr., panthenol 10 mg., benzyl alcohol 2%, propylene glycol 33.4%, sodium chloride 5 mg., water q.s.

**Indications**—For rapid relief of severe cramping pain due to smooth muscle spasm, e.g. in colic: renal, gall-bladder, intestinal, esophageal, or urinary bladder.

**Administration**—1 cc. subcutaneously or intramuscularly every 2 to 4 hours as needed.

### ANTRENYL

**Manufacturer**—Ciba Company Limited, Montreal.

**Description**—Oxyphenonium bromide, a synthetic antispasmodic and anticholinergic. It produces rapid and marked relief of gastrointestinal pain by inhibiting both motility and gastric secretion. Produces a prolonged effect by releasing antrenyl in two stages. The first dose of 5 mg., in the outer coat, is rapidly absorbed in the stomach and is effective for 4 to 6 hours. The second dose, also of 5 mg., in the core, is protected from stomach secretions by an acid-resistant membrane which dissolves in the alkaline intestinal contents. This dose is released several hours after ingestion.

**Indications**—Pain and spasm of the gastrointestinal tract, hypermotility, hypersecretion, gastritis, peptic ulcer, adjunctive therapy in renal and biliary colic.

**Administration**—The usual dose is 1 to 2 tablets morning and night with meals. Optimal effects are obtained when the tablets are taken at 8 to 12 hour intervals.

### TOLOX EXPECTORANT

**Manufacturer**—Anglo-Canadian Drug Co. Ltd., Oshawa, Ont.

**Description**—Each fluid ounce contains: Tolox 75 mg., ammonium chloride 10 gr., sodium citrate 4 gr.

**Indications**—Treatment and relief of coughs and other symptoms of congestion resulting from respiratory infections and allergies.

**Administration**—Average dose for adults is 1 or 2 teaspoonfuls every 3 hours.

Average dose for children is one-half to 1 teaspoonful every 3 hours.

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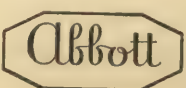


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# THE CANADIAN NURSE

## *L'Infirmière Canadienne*

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## In Time of Need

WE NURSES AS A GROUP are a very practical people. Our professional training helps to foster that characteristic — we spend very little time directing our thoughts toward the intangible. The large majority of us — working at the bedside, in the home or in the community — are concerned with very tangible situations and problems. As a result we sometimes tend to look a bit askance at any new idea directly affecting our work which seems to savor of the hypothetical and to accept it with reservations until the practical worth has been demonstrated to our satisfaction. Perhaps this has been the underlying reason for our attitude toward civil defence planning.

Mention "civil defence" and the usual reaction was, perhaps still is to some extent, to conjure up a picture of enemy planes and the H-bomb, coupled with the attitude that "It can't happen here," or "We'll all be killed anyway — so what's the use." Except for those who considered it more thoughtfully, we pictured a whole new body of agencies being painstakingly developed to meet a situation which might never materialize.

On the surface, the whole idea

seemed neither practical nor workable. Patiently and quietly, those who are immediately concerned with the evolution of disaster planning have presented the practical evidence necessary to prove that such a program is worthwhile and has a definite bearing on our contribution as good nurses and good citizens.

What has changed our thinking?

To begin with, the term "civil defence," essentially warlike in tone, is giving way to the less restricted phrase "civil disaster" — misfortune affecting the citizens of a country in general. Thought of in those terms, civil disaster planning is something which we are much more willing to accept.

Recently in Canada we have had several disasters whose scars we still bear. Torontonians will not soon forget or easily erase the havoc produced by Hurricane Hazel.

The people of Winnipeg, with the memory of one flood fresh in their minds and the possibility of another such incident an ever-present reality with the coming of Spring, are actively concerned in offsetting the effects of such disaster through organization of their public services. These exam-

ples demonstrate just what civil defence or disaster planning really is — an extension of community services *already in existence*, and coordination of their efforts with the chief objective being to save life whether the disaster be fire, flood, tornado or the explosion of an atom bomb.

One of the largest groups of citizens to attend the course of instruction at the Canadian Civil Defence College, Arnprior, was drawn recently from the ranks of the nurse educators, directors of nursing, public health organizations and other key nursing agencies. They represented every province in Canada — provinces whose civil disaster planning ranged from much activity to very little.

Naturally, they were concerned with the effect of such planning on nursing education, on hospital routine, on community health agencies. Consideration of the possible effects brought some very interesting observations, questions and comments to the fore — all the more interesting because the problems presented were already so familiar to us.

The importance of the nurse as a leader was repeatedly stressed, which, in turn, stimulated consideration of how best to develop this quality in the young women who enrol in our schools of nursing.

It will probably mean a more critical analysis of present methods in this respect. The place of the auxiliary worker — be she nursing assistant, ward aide or volunteer worker — has required clear definition for some time. Civil disaster planning simply points up the need for such definition and the importance of adequate leadership if this group is to give maximum service in time of emergency.

The curricula of Canadian schools of nursing have been, or are being subjected to rigid evaluation in all provinces. The possible effect of a large-scale disaster on the program of a school of nursing and on the lives of its students indicated where further revisions could be made — revisions

useful under peaceful conditions as well as in time of disaster.

It sparked more thought in regard to the relative effectiveness of 2-year versus 3-year programs of basic nursing education. To be even more practical, after watching a demonstration of the activation of an Advanced Treatment Center and the very effective use of casualty simulation, many a nursing arts instructor must have visualized the numerous possibilities for casualty simulation as a teaching aid. How much better to *show* the patient in shock than to *talk* about the condition.

The exceedingly well illustrated handbook, "Casualty Simulation," is available for the modest sum of \$1.00. Copies may be procured from The Queen's Printer, Ottawa, Ontario. Indeed, planning at the Federal level in casualty simulation has reached a stage which makes its use at the local level a definite possibility in the near future.

The emphasis placed upon instruction in first aid techniques varies considerably from one school of nursing to another. Such knowledge, if adequate, could be an invaluable aid in time of calamity. Consideration is already being given to which year of training and how extensive first aid training in our curricula should be. Civil disaster planning may help us determine the answer. To further aid us a new edition of the St. John Ambulance Association First Aid book has now been released and includes the most up-to-date instruction in first aid under emergency conditions.

Civil disaster planning or civil defence, then, is not the bugbear we once feared but is simply the coordination and extension of existing services. The acceptance of responsibility is almost synonymous with nursing. Is not participation in civil disaster planning another responsibility for us to accept? Might we not consider it as an extension of *our* services?

J. E. MACG.

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If your foot slips, you can always recover your balance; if your tongue slips, you can never recover your words.



# Confusing Notions of Mental health

## A Problem for Nurses

A. B. STOKES, M.D.

A HIGH OCCASION OF THIS SORT is one of good health and good cheer. For a few short days we leave the day to day responsibilities behind us and in a chosen setting meet old friends, exchange news of one another, compare experiences, seek new ideas and in a hundred and one ways consolidate our membership in a great and worthy vocational group. A feeling of respite, of comfort, of confident strength, of personal expansion and growth supplants the worries of taxing effortable practice. There is a sharp contrast between the pleasure of this sort of occasion, which on the whole is without self-conscious concern, and the recurring necessity in our working days of making sometimes grave, worrying decisions on behalf of sick people. For the moment we are walled off against the "madding crowd" to look anew and dispassionately at problems which ordinarily may be confusing and vexatious. In the present instance the problem is that of mental health.

Whenever a term like *mental health* is used there is an immediate expectancy that it will be defined. To my mind definitions are sometimes as much a hindrance as a help: whatever definition is attempted of any subject there is always a penumbra or shading off from the central defined point. In some instances the band of shading is narrow, as say in the definition of a chair; in others it is wide and inclusive of many elements not captured at the point of focus. One such is physical health. Try and define physical health and you will be in difficulties. After many imperfect attempts you will suddenly say "I can't define physical health absolutely but I know what it

is because all my professional experience is in the health field." You assert the recognition achieved by a continuing, intimate, personal experience as more useful than the definition. From my point of view mental health is in like case.

Mental health may be defined as "personal well-being in social living." The definition will not stand up to penetrative criticism nor will any other. To develop a theme of mental health around any definition would be limiting to our purpose. Instead we might look at the way in which, by reason of our experiences, it developed for us as a recognizable entity despite its complications and extensions. To do so we will take a prototype nurse or doctor and follow the stages of a maturing concept.

The "madding crowd" of Gray's *Elegy*, which I am assuming exists outside this pleasant concourse, is not a 'mad' crowd. It is *distracted* more or less by the urgent problems of personal and communal living. Physical and aspirational needs meet opposing forces and are overcome, or adjusted by mutual concessions, or emerge triumphant. Such interplays occur, recur, occur again over the long passage of marching time, so that in a very real sense life is effortful and can never be thought of in terms of unalloyed security, success, or pleasure. For most a lot of fun is gained from the hurly burly as well as a lot of hurt. Everyone slips occasionally but is soon back firm footedly. Some fall heavily and have to be helped. Of these it may be said they have broken down in living.

The breakdown in living is a matter of concern not only to the individual but also to the crowd. The urgency of effortful living and the occasional vulnerabilities of every one are circumstances which bring about the designation within the crowd of some members devoted to the well-

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Dr. Stokes is chief of staff at the Toronto Psychiatric Hospital. This paper was read at the annual convention of the Registered Nurses' Association of Ontario recently.

being of those who are in jeopardy. They are still of the crowd but are given prerogatives and privileges linked to titles, such as pastor, lawyer, politician or social worker, and to areas of service spiritual, legal, political, social and the like. Among the earliest and most privileged, linked inextricably to the Shakespearian ideal "to study for the people's welfare," are nurses and physicians with health as their area of service.

It is hard for us here to recapture our first recognition of the nature of the emotional forces in the community, which stirred our early interest in becoming nurses and physicians. Certainly we saw the personal opportunity of entering a well respected profession, of using our talents in such a way as to receive approbation and acceptance in a measure which countered any suggestion of inimicable servitude. But more, we had a very real sense of transmuting illness into wellness and thus of contributing to the welfare of others. In those more idealistic days our humanity was as involved as our intellect in making the decisions for our future.

The decision once made we entered a period of training in a social institution called a hospital. This social institution had emerged in history as a place apart where sick people were housed and cared for. When we came into the hospital most of the ill people were in bed. Their living had been disrupted by reason of heart trouble, or a cancerous growth of the womb, or a recently fractured thigh. We addressed ourselves quickly to the task of knowing all about these conditions, how they were discovered, how they had come about, what was to be done for them, what our part would be in treating the condition. Very properly we started at the beginning, learning about the structure and function of organs, about pathological processes which destroyed structure and disturbed function. We became aware of a vast array of technical procedures designed for particular investigations and specific treatments. Always during this exciting time of intellectual stimulation, by both precept and example, we were coached to a sympathetic understanding of the patient's current needs — to make him com-

fortable, to encourage the relatives and friends, to make helpful suggestions of a common sense kind at a time of stress. Now it was that we had a full sense of gratification in our vocation, that we were using an increasing expertness authoritatively and well, that we were treating disease and the person with the disease to his betterment. Our first notion of a mental health principle was born.

With increasing experience in nursing or doctoring the patients in our hospital we found there was a great deal of difference in the attitude of our patients. Whereas many were resilient and emerged from the incapacities of their physical disease to bear our cajoleries and encouragements and to want to get home, others seemed less responsive. Not infrequently the unresponsive ones, while complaining of physical symptoms, had no organic disease. They had pains, or bowel looseness, or stomach upset, or muscular weakness but nothing that could be tackled in a very direct or specific way, as it seemed. They were in the way, as it were, sometimes demanding, sometimes captious, occasionally contentious. One might be sorry for them because of an obviously disturbed family relationship, perhaps a faithless, feckless spouse, or an unhappy work situation. But more often there seemed nothing excusing in the background, and the disability became almost accusingly designated as neurotic with the implication of someone not trying or not pulling themselves together. Had we been less involved, less identified with the work of curing organic disease, we would have appreciated the operation of group rejection and the worsening of the neurotic disability because of the rejection.

Of course more obvious rejections were very evident. The disturbed, deluded puerperal psychotic, the very depressed tuberculous patient threatening suicide, or the obstreperous alcoholic were quickly transferred elsewhere perhaps to a mental hospital or refractory ward. A perfectly proper course of action would almost certainly have been associated with some thinking that these particular patients were inevitably marred by tainted stock or poor qualities of character. Only later, by the chance of occasion, would we



sometimes meet these same people and to our somewhat embarrassed astonishment find them hale and hearty. We wondered how recovery had come about and in that surmise propounded our second mental health principle that disturbed people sometimes recover.

These general hospital experiences of the vagaries of human behavior became tremendously expanded when, with training completed, we entered into family or public health practice. Now the totality of illness rather than a selected group of organically ill persons became our concern. Certainly, chronic instances of organic disease or organic cases requiring rehabilitation were plentiful for our ministrations: but now we were thrown more on our own resources. Over and above these technical accomplishments suitable for community work we had to rely on ourselves as persons and use ourselves as instruments of medical purpose. To help the people we were supposed to help some important personal relationships had to be established and used.

So long as we could still do a dressing, or arrange a diet, or give an injection we were the more confident. But in the new, to us, community scene we found ourselves meeting disablement which more and more seemed unrelated to physical disease although frequently associated with physical symptoms. We might rush in with nostrums and placebos but inevitably a time would come to face the fact that this disability, as crippling as any, arose within the circumstances of life adjustment of the individual. Now, call them neurotic or psychotic as we may, they were problems of ill health perhaps reminding us of the World Health Organization's definition "that health is a state of complete physical, mental and social well being, not merely the absence of disease or infirmity."

At this stage of an interest maintained by the realities of the suffering and distress we were witnessing, we might have made a number of observations, some external to ourselves, some within ourselves. Outside the sphere of our own activity we noticed that people, with difficulties somewhat similar to our patient's, sought help through some human relationship important to them. They seemed to get

a tremendous support and encouragement maybe from a priest, or a friend, or in the instance of a young person from a schoolmaster. Such supports seemed to be the more necessary the more family cohesion was lacking. Where the family grouping was accepting, not of necessity in an uncritical way but in a manner which maintained bonds of relationship despite all upset, then the individual complaintiveness seemed less. These supportive relationships, as we observed them in the scene around us, were not dependent on material wealth or the appurtenances of easy living but on the quality of human experiencing. Within ourselves, perhaps suddenly, we realized that our patients were really seeking this quality of human regard from us, the privileged nurse or doctor to whom their homes and selves were opened. In short we found that to help persons in their living we must start, despite appearances to the contrary, with an appreciation of their worth. Sympathy from above was not enough. Understanding, in the sense of knowing and feeling as if within, was of paramount importance in working with the patient to a healthy outcome.

A realization of this sort was not reached without some trauma to ourselves. The demands of empathizing, as this knowing and feeling as if within is called, include a continuous testing of ourselves in a large variety of human relationships. The testing imposes a double burden — to be feelingly involved and to appraise the involvement objectively so that it might be used in practical fashion — to restructure the pattern of our patient's living, to meet his varying occasions. A new kind of thinking started for us which harked back to that human interest in people which initiated our professional concern in healing.

But, as we were about our business in the community looking at and testing ways of helping ill people, whether their disablement was associated with organic disease or not, we became aware of other happenings. The crowd, while no doubt using expediently the strength of family groupings, the aids of the helping professions, and the supports of its focal organizations still



suffered its casualties impatiently. It tended to act impulsively either for the patient claiming short cut magical cures, or against the patient by reject attitudes and procedures. As to the former, each new hope, whether a miracle drug or an ingenious shock technique or some device of surgery or suggestion, was built up by the processes of communication into an established certain cure. As to the latter, each prick in the bubble of hope, was followed by a metaphorical washing of hands and a withdrawal of favor, sometimes even of interest. "Sink or swim" was the attitude with sinking equal to death and swimming the labored incompetence of a potentially worthy citizen contributing to the public weal. It was this combination of "blow hot, blow cold" "filling and backing" which we found disconcerting. The steady advancement of knowledge and control through knowledge of breakdown in living seemed for us the more remote.

However, because of our discipline in nursing or doctoring, although aware of these happenings we tried neither to endorse nor promulgate the impulsive hopes or rejections of the crowd. Having sampled for ourselves the effects of our personal relationships to our patients and seen some of the consequences of impulsive crowd action, we gave more attention to and placed greater credence on the kinds of social groupings which promote individual strengths. As opportunity served we may have encouraged our patient, in the light of our understanding of his needs, to take part in a group, perhaps a remedial group or one devoted to rehabilitation exercises, perhaps an old age group or a youth activity at a Y.M.C.A. Later we may have tried for an acceptance within a vocational group, an acceptance brought about, perhaps, despite a disability but with the recognition of assets for the job in hand. Insofar as our progressing experience warranted it, we came to the recognition that society was not really a haphazard crowd of people but was made up of fluctuant groupings each with some internal strength and some with an enormous capacity for incorporating and sustaining the most unlikely people. Occasionally we glimpsed

within a grouping the operation of family-like relations, not only positive in terms of regard and affection but negative in terms of warring rivalries and rebellion against authority. Such occasional insights built up into a slow realization that our patients looked on us, and played their parts towards us and other people, in a manner determined by their particular family experiences. On looking at ourselves we might have seen with clearer understanding how our feelings and attitudes towards people and situations were brought into being by our earliest life relationships with parents, brothers and sisters. We would have wondered about the mode of incorporation of these events within ourselves so that 20 or 30 years later they still, in part, determine our actions.

At this stage we came up against the problems of life development, personality integration and the capturing of experience, both knowing and feeling, within the physical substance of the brain. If the brain is the seat of learning, not only intellectual but emotional, then its function may be shifted both by methods of relearning and methods of physical modification. The great ideational chasm, which had almost certainly disturbed us hitherto, between the so-called psychological and the so-called physical could now be bridged. The personal adaptive functioning of the brain was continuously related to present circumstances but the relationships included important elements from the past. To arrive at this position we had used a general vocational experience. By using common sense and insightful understanding we had been more helpful to our patients in getting them on their feet in a hurly burly world. To go further would mean a degree of specialization.

Specialization need not concern us unduly here excepting to comment on the balance and the detail of the notion of mental health we may have formed in our general practice of nursing or doctoring. If we have decided to get a more intimate knowledge of specific work wholly devoted to mental illness we enter a psychiatric institute or a mental hospital. Here we find very many patients including those whom we previously noted as being sent on from the general hospital. It would

strike us immediately that most are up and about and the relatively few are confined to bed by reason of organic disease. Some of the patients, up and about, have long standing brain pathology subsequent to infections, or trauma, or tumors, or degenerative processes. Nonetheless, and contrary to a general hospital, the etiological emphasis is not on physical disease. Particularly in the mental hospital we would learn that many have been resident for years. Yet if we looked carefully through their records we would have difficulty in finding a substantial number with hereditary predisposition to mental disease. The notion of an inevitably malignant gene producing mental disturbance is as untenable as, say, with diabetes mellitus.

Another point would strike us, reviving the memory of our astonishment at seeing in those earlier days the occasional recovery — very many patients recover and are discharged to home and family as competent worthy people. We would see that each of the treatment methods, which in our community practice had been bruited abroad as the one and only cure, had representation in the hospital's work. Each would be employed circumspectly with proper selection of cases. One here would be on a modern tranquilizing drug, there a form of electric convulsive therapy, this one would be receiving insulin shock therapy and that one has had a lobotomy. We would recognize that none is as yet specific but that patient researches are continuously being undertaken to find out why these treatments act when they do act and in what circumstances they act best. It would be our part to help in such research enquiries.

Although these physical treatments were often dramatic in their effect we would see that in other instances the treatment of choice was psychotherapy. We would find that there was

nothing mystical about such treatment. Despite many variations of technique the essential elements were the establishment of a personal relationship with a physician, which was used to explore past feelings and attitudes in order that unlearning might be followed by new learning. Indeed, we would find ourselves continuously involved in processes of relationship which embraced the same psychotherapeutic principles.

One particular surprise would await us. With our patients up and about we would find it necessary to organize our ward as a social group, that the interplays of personality might be moulded as far as possible into a mutually supportive whole. The interplays will be of particular importance in the period of rehabilitation and weaning from hospital to a well founded family and vocational adjustment.

These specialist studies will reveal great gaps in knowledge and progress by trial and error methods. The state of practice will be very reminiscent of the early days of medicine and surgery: firm preventive measures will still seem elusive, although glimmerings of opportunity will be marking the right directions.

With such a general and special experience behind us, nurse and doctor will have a recognition of mental health. Genetic, physical, psychological and social elements combine systematically and without schism into a personal whole, which meets the affronts and favors of living steadfastly and with resilience. To repair a breakdown in living, physical, psychological and social methods are to hand. To use them common sense and disciplined enthusiasm are not enough but when allied to a sensitivity in human relations small shifts of adjustment will accomplish great good in terms of "personal well being in social living."

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Removal of tonsils and adenoids should be undertaken only after a careful study by a physician familiar with the child's medical history. Tonsillectomy and adenoidectomy are very valuable procedures when needed but they are not the cure-alls some people

believe. A study carried on in a private school over a 20-year period showed that removal of adenoids and tonsils made no difference in reducing the number of colds in children in the first three grades.

— *Scope Weekly*



# Impact of Chronic Illness

ELISABETH C. PHILLIPS, B.S., M.A.

**I**N ORDER THAT WE MAY ALL start out thinking in the same terms, I would like to give you a definition of chronic illness. This is one that has been prepared by the National Commission on Chronic Illness in the United States and it is, I believe, as clear and specific as any that I have ever come across.

Chronic disease or impairment comprises all impairments or deviations from normal which have one or more of the following characteristics: Are permanent; leave residual disabilities; are caused by non-reversible, pathological alterations; require special training of the patient for rehabilitation; may be expected to require a long period of supervision, observation or care.

The term "long-term patients" includes only those persons suffering from chronic disease or impairment who require a prolonged period of care, that is, who are likely to need care for a continuous period of more than three months in an institution or at home, such care to include medical supervision and/or assistance in achieving a higher level of care and independence.

In the United States chronic illness is responsible for 70 per cent of all invalidism and partial disability and one-sixth of our total population are its victims. In Canada it has been estimated that there are one million permanently disabled with nearly half of these totally disabled, and that the disabled make up 3 per cent of the total population between age 18 to 64 years.

Chronic illness occurs half again as frequently among the lowest income

groups as among those in even slightly higher brackets.

Chronic illness is perhaps the most important, urgent and complex problem that society faces today in its attempt to care for its members and itself.

We all know that both the numbers and percentages of persons who are over 45 years of age are increasing rapidly. But what many people do not yet realize is the companion fact that of those persons who are well at the age of 45, 10 per cent will acquire, during the next five years, a chronic illness or major impairment which will require at least periodic, if not constant medical care for the remainder of their lives. Nearly 25 per cent of those who are well at age 60 will develop a chronic illness before they are 65. Forty per cent of those who are well at 70, and 57 per cent of those who are well at 80, will become chronically ill within the next five years. In other words, as our population increases in its average age, so will chronic illness increase. Sixty per cent of all disabled people in Canada are over 45 years of age.

Of course, chronic illness is not limited to persons over 65, nor on the other hand, is aging synonymous with chronic illness. We must never forget that fact, but all the same, an aged population is also the one most vulnerable to the inroads of long-term illness.

Even with an accepted definition in mind, the words "chronic illness" have a very different meaning to different people. To one they suggest something that is hopeless; to another something that is going to last a long time; to another, something that must be endured; to another something that comes to most of us with age; and to yet another, something disagreeable that must be shut out. To some nurses chronic illness means frustration, boredom or even disgust; to others, it is an almost unexplored area of service which offers excitement and challenge.

There is *one thing* that chronic ill-

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This is the first in a series of four papers by Miss Phillips that were presented at an institute on Nursing Aspects in Rehabilitation and Care of the Chronically Ill, held under the auspices of the School of Nursing, Dalhousie University, Halifax.



ness means to all of us — to those in the health and social welfare professions, to local, national and international communities, to individual families and patients, to society as a whole. Chronic illness is a problem that to date is only partially solved.

Of course, there are all degrees of chronic illness. In its broadest sense, almost everyone of us could qualify for membership in that not-too-exclusive club of the chronically ill. Our eye sight is impaired, so we wear glasses; our teeth have petered out and we have a pivot tooth or a bridge or even more! Our blood pressure is elevated, so we try not to lose our tempers; some of us wear arch supports; others take a vitamin pill each day; we complain of our sinuses, our ulcers, our joints, our stiff muscles. There are probably some of us who have a specific disease such as diabetes, arthritis or undulant fever. Yes, most of us know, and will admit, that we have some sort of a chronic physical disability even if we won't go so far as to admit to mental or emotional illness. Our attention in this series of papers will not be directed to the needs of people such as we who, outwardly, seem to be well or nearly so, and who are able to carry their share of work and play. We will be thinking, rather, of those who are disabled by some illness or impairment and how their lives can be enriched.

In the United States for the past five years, we have had a National Commission on Chronic Illness. This has been supported by a large number of national organizations including nursing. This is the commission whose definition I quoted above. In terms of this definition in the United States there are over five million chronically disabled persons. In Canada the number is nearly one million, exclusive of those with disabling mental illness. It has been estimated that for every chronically ill patient who is institutionalized there are at least three others who have never had adequate medical care, but who need it.

We must realize that a vast number of the chronically ill who are under medical care in institutions or at home are receiving what amounts to custodial care only. Custodial care may or may not be excellent so far as it

goes, but it falls far short of even the most modest goals set for rehabilitation programs. It is not strange, therefore, that we are staggered by the enormity of the job ahead of us.

It has been carefully estimated that probably some seventy per cent of the chronically ill can be cared for at home satisfactorily if the communities in which they live have the following facilities in sufficient numbers:

1. Physicians, both private and clinic, who will make home visits.
2. Visiting nurses, practical nurses on the staff of visiting nurse associations or generalized public health nurses who are permitted to carry bedside programs.
3. Supervised homemakers.
4. Social workers who are able to make home visits.
5. Restorative services which will include occupational therapy, physical therapy, rehabilitation, vocational guidance and recreation.

Services for feeding many chronically ill and aged patients are now being seriously considered as a necessary community facility if these people are to remain in their own homes. In England, "Meals-on-Wheels" were established shortly after the war by many large cities. Such services provide hot meals two or three times a week to patients at home who cannot, themselves, shop and cook and who have no one to do it for them on a daily basis. The projects are all subsidized, but each recipient does pay something, usually six pence to a shilling for each meal.

"Luncheon Clubs" have been formed for the aged and infirm that provide social and sometimes educational activities as well as the meal itself.

Of key importance in the entire program for the care of the chronically ill are rehabilitation services. Vocational rehabilitation is, of course, important, but ability to return to competitive employment should not be the *sole* criterion of success in rehabilitation. A large proportion of the chronically ill will, if given the right type and quantity of help from physical therapists, occupational therapists and nurses skilled in rehabilitative measures, be able to take a more active part in normal living. Almost all of them will be able to either participate in or take entire care of their personal

hygienic needs, be able to feed themselves and become quite self-directing in diversional activities. The chronically ill may be divided into several categories:

1. The group that has had some impairment since birth. These people do not know what it would be like to be without it, but we must help them to live the fullest lives possible.

2. The group who acquired their impairment in childhood. These have probably adapted to their handicap but sometimes far from adequately and so they need help. The handicapped child's reactions are different from those of the person crippled in adult life who must make a major adjustment to a life unlike the former one. The child is frequently not greatly disturbed by a sense of difference, but may suffer from the difficulty of developing in an essentially unreal world which lacks the normal elements of education and play with contemporaries and the stimulus of physical adventure.

3. Those who acquired their handicap in adulthood, at a time when they are near their peak of productiveness. These people respond to the handicap in either of two ways — they are floored by it, or else they adjust to it well or poorly, depending on the adequateness of the help they receive.

4. Those who acquired their impairment after middle age. Many times, the impairment has had a very slow onset, in contrast to those occurring in the other age groups. Acceptance is usually marked by resignation or half-veiled rebellion.

In order to insure the efficient operation of any medical program for the care of the chronically ill — and this includes nursing as well as the other medical services — it is necessary that all persons attempting to carry out such a program have an understanding of the patient's reactions, fears and difficulties during the time when she is applying for medical help, undergoing treatment, and convalescing. The common deterrent to seeking medical aid are:

1. Ignorance of availability of such services and how to go about securing them.

2. Fear of the physical examination itself, and of the treatment that will follow.

3. Fear of the implications of helplessness and dependence once the patient "gives in" and asks for the help.

4. Concern for the cost of the care, and pride that makes him say, "If I can't pay for it, I can't have it." This is particularly true in the older age groups.

5. There is another deterrent to seeking help — the patient has become dependent upon his illness and gets satisfaction from it — strange as this may seem to others.

The reluctance to accept the help offered stems from much the same causes. As we become more aware of the implications of psychosomatic medicine, the reasons for many types of behavior in chronically ill patients become more clear to us. Anxiety and depression, for instance, are typical manifestations of the cardiac patient and of his family. This anxiety is often out of all proportion to the need for it as measured in terms of the disease itself. Everything must, therefore, be done to allay it. Unless it is allayed, recovery from the disease itself will be postponed. In extreme cases we now recognize the condition known as "cardiac neurosis" and realize that the only lasting treatment for this is psychotherapy.

A few years ago a test of eight basic emotional needs was administered to a group of 87 crippled children and 193 non-crippled children. No significant differences were found between the two groups in the presence and fulfillment of their needs which were found to be:

Belonging; achievement; economic security; freedom from fear; love and affection; freedom from guilt; decision making; understanding the world.

For both groups, the need to be free from fear was the strongest while the need for love and affection appeared to be over-met for the handicapped by over-protective parents, teachers and nurses. Both groups showed a need to be free from feelings of guilt, but the need appeared to be stronger among the non-crippled. Although in all emotional areas the children seemed strikingly similar, wide differences appeared among the individual children. Among the crippled children, the individual deviations indicated maladjustment based on mis-



understanding of the implications and limitations of the physical handicap.

Another study to determine the social relationships among a group of physically handicapped children, between the ages of 10 and 14, indicated that the child's intelligence and degree of independence of assistance (in inverse ratio to the disability) are significant factors in the acceptance of the handicapped child by other children. The obviousness of the handicapping defect and scores on personality tests had no significant correlation with the children's acceptability to the group.

Let us think now of what lasting illness of various kinds does to the individuals involved. In our culture the chronically ill person is often (though not always) judged to be inferior, that of a lower status than ourselves. He is looked down upon and is pitied. We should do everything in our power to place emphasis on qualities and characteristics that handicapped persons have in common with normal individuals. We must remember that the physical impairment which an individual has is only one part of the whole difficulty. The social and psychological elements are equally important. Dr. William C. Menninger of the Menninger Psychiatric Clinic in Topeka, Kansas, has pointed out that the adjustment of the crippled child or adult is affected by the attitudes of others towards his handicap. These attitudes are frequently irrational and hostile, running the gamut from curiosity, through pity and oversolicitousness, to fear, repugnance and complete rejection.

A major effort must be made to help people understand their prejudices towards the handicapped, or the chronically ill, in order to improve the well-being and opportunities of the patient. An attitude of sympathetic understanding on the part of families and all workers dealing with the handicapped person helps him to accept the reality of his physical impairment and difference from other people, and to find the compensatory psychological satisfactions provided by special educational and recreational opportunities and varied social relationships.

In our work with chronically ill patients, our own attitudes frequently obstruct us and prevent us from giv-

ing the kind of care that we should. We encounter our own mixed feelings about persons who are different from us and in many of us there probably are vestiges of our early childhood anxiety about differences. In any group of children, we can note anxiety regarding the child who is a stranger to them until they have felt him out and have been assured of his likeness to them. Perhaps we have an unconscious fear that this thing that has happened to the patient may also happen to us. One of our abstacles that we must overcome is our desire, as nurses, to over-protect patients. This very over-protection serves to set the disabled person apart from us and to emphasize his chronic handicapping. Perhaps this is what makes us tend to view these individuals in terms of their disabilities alone and to plan for their disabilities rather than to help them plan for themselves. We will help the handicapped individual only as we understand his needs as a person, not only the needs created by his handicap, but also those that he has in common with other human beings. Let us, then, examine some of these emotional drives which the chronically ill, as well as we who are well, have in common:

- An urge towards aggressive dominance.

- A longing for submissive security.

- A need for satisfaction of physiological demands.

- A desire to love and to be loved.

- A drive to obtain an opportunity for self-realization.

- A wish to shift responsibility for a frustration on to the shoulders of another.

You and I have these same characteristics, so does the physician, the banker and the common laborer. The well-adjusted person has learned to keep these things in balance, but this adjustment is easily upset by transitory fatigue, as well as lasting illness.

Emotional problems are closely related to disease in the elderly, as disease represents a greater threat in age than in youth. Old age has characteristic organic mental diseases and functional personality disorders which may yield to proper therapy.

It may be helpful for us, who give care to the chronically ill, to try to



evaluate the relative pressures of these emotional factors in each individual case and to realize the effect that just being chronically ill may have, because of these drives. A case story will help us to understand.

Mr. Ansko, 43 years old, was a very successful travelling salesman for 22 years. His job necessitated long hours and much travelling. It continually called for great mental activity and made great demands upon his originality. He led a full and extremely active life and he saved little of his income. Suddenly he was given a diagnosis of diabetes. A new type of life was described to him by his physician. He must slow down, he must eat regularly and carefully and only those foods on his diet list. He could no longer travel daily. He must give careful attention to his hygiene — not cut himself while shaving, be particularly careful of his feet, and so on. Then he must learn to give himself insulin, what to do should he get too much or too little of it and, above all, he must see his physician periodically.

This patient in the first rush of fear, sought and secured a job of selling "over the counter," but soon discovered that he hated it. It no longer gave him an opportunity for self-determination and expression as his travelling job had. Night after night he went to his room, closed the door and read until the wee small hours. He was disagreeable, his temper was short, both on the job and at home. He disregarded his diet and blamed his wife for "not preparing meals that were fit to eat." He forgot to take his insulin, or broke the syringe or failed to renew the prescription. He broke his appointment with his physician. He had fits of depression that became increasingly frequent. In an effort to overcome them, he went on all night parties with his friends or on "food binges" when alone, flaunting the regime laid down by his physician.

Yet, Mr. Ansko was a man far above the average in intelligence. He understood the rationale of his diet, why he must be careful and conserve his strength. What then made him behave in the way he did? Could it be that his desire for aggressive dominance had become exaggerated, that he resented his illness and that "being a diabetic" lowered him in his own eyes and, he

believed, in the eyes of others? Could it be that he had lost his sense of security in life? Could it be that he was worried that he would no longer be able to support his family? Had the psychological impact of learning that he had a chronic disease been traumatic? Was he attempting to shift the responsibility for this illness to his wife's shoulders? Could it be that through all of this behavior he was attempting to deny the very existence of the disease?

It is quite possible that affirmative answers to any or all of these queries might well be made. It is equally possible that had more thought been given to the way in which the disease was described to him and the way in which his wife received the news and adjusted to his illness — had all of these things been done somewhat differently — the impact of this particular chronic illness could have been lessened and a much happier adjustment to the disease could have been made.

Human behavior is a fascinating subject. We who dare to give care to the chronically ill must learn as much as we possibly can about the many *possible* behaviors our patients may exhibit. This will do three things — all equally important. It will help us create empathy with the patient and by so doing accept the behavior resulting from the disease itself. It will put us in a position where we can give him real help, which is even more important. It will do much to prevent our own frustration and discouragement while caring for long-term patients. In other words, it helps us to be *therapeutic* nurses, happy in our patient relationships, because we understand something of the motivation of their behavior as well as our own.

All of this works equally well with the opposite type of patient — the one who revels in his illness and follows every medical suggestion to the *nth* degree. This is the patient who resists strongly all efforts to help him to help himself, who wants to remain ill and dependent, although he may deny this most emphatically.

Almost all adults and older children go through a period of mourning when they are told that they have a chronic illness. This is natural as they begin to realize that life will be affected circumstantially and psychologically in

varied ways and in varying degrees. Insofar as these conditions bring change, the factors determining the nature and the degree of the individual's response are his age, sex, prior life experience, prior personal development and the timing of the onset of disability in relation to other events of his life.

This factor of timing is sometimes decisive. For example, a man immersed in humiliation and defeat at being unemployed, may sustain an injury or fall ill. At such a time the disability may be seized upon and used to the utmost as a more acceptable basis for being unemployed than not being wanted in the labor market. The same mishap in time of employment might not have brought the same gratifications and therefore, not being useful, would not be clung to in the same way.

Or in old age, when the future is uncertain and life in general has become frustrating, illness or a handicap may be used as the means to return to early infantile gratifications. The person may derive attention and a feeling of safety and comfort through the care which his disability conscripts. This is not necessarily the case, however, for if the person has well entrenched patterns of self-dependence, he may resist his disability or deny its existence through refusing medical care and attempting to carry on as of old.

An important factor determining his choice of a solution may be the response of family members to his disability. Their anxious over-protection may drive him to further lengths in denying his limitations, for it may encourage regression. Their indifference and neglect may provoke regression in order to command attention or it may block him in getting help which he genuinely needs.

Likewise in adolescence when the young person has not a secure place in the adult world and when he has considerable anxiety about his status among his peers, a physical handicap or chronic

illness, which limits his activity may be deeply disturbing. He may solve the problem by regression to childhood or he, too, may resist the limiting reality of his handicap through over-reaching himself in activity and through refusing to use proper measures to safeguard his welfare. Again, decisive factors in determining the nature of his response are his prior personality development and the response of others, notably his family and his friends, to his disability. Above all he may need help in planning realistically for the future.\*

The care of the chronically ill is one of the most important problems facing society today. It is, of course, an interdisciplinary problem, but this does not mean that the nursing profession should not take a leadership role in solving many aspects of it. Nurses must, of course, work within a societal and organizational framework, but we do need to define and work on the nursing problems in these areas. This means that we need first to experiment in ways of providing a greater quantity and quality of nursing for these patients; second, we need to see how we can prepare nurses in in-service educational programs as well as in basic and advanced studies to render this type of nursing, both directly and through the supervision and direction of auxiliary personnel. It is not possible for us to shift our responsibilities for these things to other shoulders.

While we are working on these particular aspects of care to the chronically ill, we need to seek and then make use of opportunities for us as nurses to work with members of the other disciplines to solve those other aspects of the problem which can be solved only through an inter-disciplinary approach.

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\* Common Human Needs by Charlotte Towle, published by the American Association of Social Workers, 1 Park Avenue, New York 16.

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When counting your birthdays, don't peer ruefully into the mirror to add up your new wrinkles, if any. Rather rejoice in the fact that you have another full year of new friends, new experiences, new blessings to

add to your wonderful collection of lifetime memories; to make you a wiser and better person for the year to come.

— ESTHER BALDWIN YORK



# NURSING EDUCATION

## Life, Profession and School

SIR FRED CLARKE

A N OLD FRIEND OF MINE once wrote a very able book to which he gave a title wherein the word "Evolution" was used. When it was suggested to him that the book itself had very little to say about any "Evolution" his reply was: "Yes, I know, but the publishers had the title they wanted, and I had a title under which I could say what I wanted."

So much for titles. I am afraid I must offer the same kind of excuse for the title I have chosen for this paper. It is just a wide-open umbrella under which I can find room for what I wish to say.

Stated in general terms the task I am attempting is one of a perspective sketch. I wish to look at our problem of the education of nurses from the outside, as it were, so as to view it in its setting of current thought and practice, both in education and in the wider field of social and cultural tendency.

A venturesome undertaking, to be sure. For the world of thought and action and cultural movement, amid which our problem is to be seen, seems to grow increasingly chaotic. It is a world where, to use an Irishism, only the strong heads can keep their feet. Fortunately, our topic itself helps us. I know very little even yet about the problems of nursing education, and most of what I do know has been learned in Canada. But, coming fresh to some study of the question, I have formed at least one overwhelmingly strong impression. It is this: that no question of modern education can be more *typical*, more *representative*, of all the major issues than that of the education of nurses. Those who wish to clarify their thinking among the

tangled threads of education today could find no better specific for their purpose than a study such as we are pursuing here. For it raises, and raises inevitably, all the major issues. That in itself is quite sufficient justification for the very comprehensive report which the Survey has arrived at under the far-seeing guidance of Professor Weir. In Socratic fashion he has followed the argument wherever it leads, and he has found, as all honest students must find, that it leads not only into every department of our educational thought and practice, but into the very roots of our common culture and into the fundamentals of our social structure. Truly, we are engaged on no small undertaking.

Let me illustrate the point by mentioning a few of the issues that arise. To begin with, we are concerned, in the function of nursing, with an indispensable social necessity. Done well or done badly, the job must be *done*, and the loss is immediate if it is not well done. Here at once we have both an urgent question of vocational education and a great issue in social policy, if the necessary supply of skill is to be both forthcoming and readily available.

Then the service itself becomes increasingly technical, demanding an ever-growing degree of specialized training. Here is an issue that is disturbing us all, in almost every field of education today, and it is no exaggeration to say that the fate of society depends, in large measure, upon the wise solution of it. How are we to provide for the carrying of this ever-growing load of technical *expertise* and yet save and strengthen the human souls of men and women? A society



consisting wholly or largely of "mere" experts: of people who are just experts and nothing more — what a horror to contemplate! Yet there seems to be some danger of it and the issue is nowhere more acute than in this field of the education of nurses.

Next, we may glance at the professionalizing process which gathers such strength in so many callings, in addition to that of nursing. There can be no doubt that change in the ambitions and status of women has given a powerful impetus to the process, which again, is full of danger. What is the recognized standard of competence to be? How is it to be achieved and maintained? What rights is the organized profession to exercise? How can the dangers of privilege be offset so as to safeguard the community without injury to the profession? Here are momentous questions both of education and of social control, and parallels to them can be found on every hand.

Finally, I will take note of another unsolved conundrum that is illustrated by our topic. It is of a more purely educational character and so can be used to lead straight into the main discussion. It is a question at least as old as Plato, and his discussion of it in the "Republic" is still relevant to our own case. It is this: What is to be the relation of so-called general (or liberal) to so-called special (or vocational) education?

How will that relation, when determined, be expressed, both in the educational progression of the individual and in the varied provision of educational means that the community must offer? In particular — in the case of nursing education, for instance, — what kind and degree of "general" education shall be demanded as a qualification for entrance upon specialized training. And again — perhaps even more momentous — what guarantees of continued cultural development of a broad human mind can be associated with or derived from the specialized training itself?

I call this last question particularly momentous. Why? For many reasons, the nature of which I can illustrate briefly. Are we quite sure that a preliminary course of so-called "liberal" training, given in the usual way, and

carried as far as you like, is in itself a sure guarantee against the narrowing and dehumanizing influence of closely professional studies? Can we be quite sure that the "liberal" training has taken firm hold and that there will be no back-sliding? For an answer, look around on the world of successful professional people.

Again, is there any profession which requires more than nursing, that its professional training shall itself be penetrated through and through with a rich and liberal human significance, so that the clinical thermometer and the compress become, in themselves, symbols of salvation of more than a physical kind? Can we afford to make the same cardinal mistakes in the training of nurses that we made in the past in the training of teachers, where we gave the narrowest and most illiberal of trainings for what should be the broadest and most liberal of professions?

It is this need for a liberal handling of the technical training itself that constitutes a strong argument for associating at least the higher training of nurses with the university, provided always that the salt of the university retains its savor. I shall return to this point later. Here I wish to express a growing doubt about the validity of the distinction between "General" and "Special" education as it is currently drawn. The doubt, I think goes to the root of the matter. On the one hand I see men and women who have succeeded in drawing the means of fullness of life out of the seeming technicalities of vocational training. Such people find water-springs in a dry ground. Or, like Saul in Israel, they set out on the humble task of seeking the strayed donkeys and find a kingdom. For one, the building of motor cars, for another the management of a schooner, for another the cultivation of a farm, yes, even the management of a household may become the gateway of emancipation into a satisfying life.

On the other hand, I see men and women of alleged "liberal" learning whose only capacity seems to be to go on accumulating more and more of the same sort: walking museums, whose contents rattle more and more drily and harshly as life goes on.

Which of these has had the "liberal" training? Please do not misunderstand me. My point is not to decry so-called "General" education: anything but that! It is rather to emphasize the view that a course of education is to be judged by its product rather than by the content of its program. That is liberal which produces the liberal and special which produces the special. And the difference is quite as much a matter of spirit and atmosphere as of formal content on paper.

I think we have here the crucial educational issue for a modern democratic community where each must discharge his proper skilful task and all must share in, and contribute to the common cultural life. We have not really faced the issue yet, largely because we have been obsessed by a formal distinction between the liberal and the vocational, which is largely traditional, and exists today very much on paper.

Let me illustrate by a direct question: What percentage of the young people of our universities — yes — even in our high schools — are there, in the last resort, for any other than a vocational motive? Insistently, in season and out of season, we have linked formal education with *success*. That has been our real faith, our real working philosophy. Some of us have gone so far as to work out laboriously and in true modern fashion the comparative cash value of various levels of education; public school in hundreds, high school in thousands, and university in tens of thousands of dollars. And our young people have responded. Why should they not, to a faith which their elders hold so fervently? No wonder that, in their secret hearts, many of them look upon our fine "inspirational talks" about the value of education in itself as just so much insincere bunk.

The Nemesis for all this may be already at the door. I shall be immensely relieved if the next few years do not bring a violent popular reaction against the whole of our elaborate provision for formal education in school and university as a huge fraud. Unfair, no doubt, but it will be one more charge of the younger generation against the older that the latter has held out promises which it cannot

fulfil. The donkey has made the painful journey and there are no carrots at the end of it. It is a little late in the day now to turn and rebuke the donkey for worldliness and to assure him that he has his reward in a much more spiritual and lasting sustenance than carrots.

Clearly it is the philosophy that is wrong, particularly wrong in the insincere guise of idealism behind which it hides the true grossness of its inspiration. In truth, where our effort should have been to liberalize the vocational we have succeeded only in vocationalizing the liberal, and have fouled the feeding trough of culture in the process.

The fundamental revision of values that is called for will have to extend far beyond the field of education in the formal sense. Here it is enough to repeat that, largely because of this failure, modern democracy has hardly begun to solve its real problem; since neither in the individual life nor in the life and culture of society as a whole has it succeeded in integrating the Useful and the Satisfying; the Necessary and the Fine; the Vocational and the Human; the Specialist and the Man.

Spurious solutions are around us in plenty. Among them one might mention Efficiency, the ideal of triumphant techniques: "Service offered usually only in return for a dividend, and combining, often unpleasantly, the lubricating grease of business with the treacle of sentimentality — even at its best its weakness is apparent in its vagueness; then the ideal of the "Good Mixer," in which I feel at times the philosophy of Professor Dewey seems to culminate; or again, the ideal of Conventional Conformity of the "Hundred-percenter," which one might gather, is satisfying to so many.

The real inadequacy of them all is evident in the vast reservoir of dissatisfaction that they leave behind, like a lake at the foot of a glacier. The lake is now growing turbid and agitated and threatens to give rise to a torrent. Its presence and the menace of it is the measure of our problem; a problem of education through and through since the threat comes not from an outside source at all, but from the bewildered minds and consciences of men and



women who feel themselves betrayed by the old gods, yet need strength and guidance in the painful task of finding more satisfying objects of devotion.

Note again, then, how typical and representative our problem of nursing education is, set in the midst of a society where men are in danger of losing their souls in a vain effort to gain the world. Nursing, with the intense humanity of its mission, the wide diversity of its contacts with the life of men, and the combined concentration and sympathy that it calls for in those who practice it: is any profession more concerned with the

supreme task of keeping body and soul together in much more than a merely physical sense?

So the claims of nursing education offer a most favorable ground for testing out the validity of our principles. To that task we will now proceed — the consideration of the education of nurses as a model for the whole problem of an integrated education that will keep body and soul together, unify life and vocation, and build a well-proportioned scheme of values so as to guarantee richness of life without prejudicing wholeness and effectiveness.

*(To be continued in August)*

## A Future Nurses' Club

TO HOLD ITS PLACE IN THE COMPETITION to attract promising high school graduates into its ranks, the nursing profession is continually casting about for new and attractive means of presenting information about itself. In the United States, Future Nurses' Clubs have already attained a comparatively firm footing and the trend is beginning to be accepted in Canada. The number of Canadian clubs organized up to the present is very limited — the one associated with the Sherbrooke Hospital School of Nursing, Sherbrooke, Quebec is a very recent addition and possibly the only branch in Eastern Canada.

The objectives of a Future Nurses' Club are few and very simple: (a) To acquaint students with the nursing profession. (b) To give students an understanding of the necessary requirements for entrance into the nursing profession. (c) To afford an opportunity for prospective student nurses to meet each other. Those who join are in no way obligated either to choose nursing as a vocation or to enter a particular school, should a career in nursing appeal. Membership is usually open to those in the senior grades of basic education but, in the case of the Sherbrooke club, has also been extended to high school graduates who are still too young to enroll as student nurses.

Programs at the meetings are designed to give members the opportunity to find out about nursing in general. Informal chats with student or graduate nurses; observation of student nurses in action either in the demonstration room or on the ward; visits to the various hospital departments — all these provide the prospective candidate with

first-hand information about nursing and the life of a nurse, on and off duty. These meetings provide the means to give, in greater and more satisfying detail, the information necessary to interest educated, capable young women in nursing. Hospital visiting days for high school students or visits to schools by nurses as part of a Career Day program have provided, and still do, valuable but fleeting contacts lacking the personal touch which can be accomplished through an organization such as a Future Nurses' Club.

Sponsorship of such a club may be undertaken by a hospital but could quite conceivably be a project for an alumnae association, a provincial chapter or even a Home and School group. The Sherbrooke Club is the brain-child of the hospital's capable and energetic director of nursing education, Miss G. Norris. Along with her assistant, Miss M. Beckwith, she acts as adviser to an executive comprised of representatives from the various high schools in the immediate and surrounding areas. Sponsors of the club are Miss C. R. Aitkenhead, director of nursing; Mrs. W. H. Jones, recruitment committee convener; J. Whitman, president of the Student Council; Dr. A. N. Langford, professor of biology, Bishop's University; Dr. W. J. Klinck, chairman of the nursing committee; Dr. S. Marcus, attending physician.

One interesting feature of the executive of this club has been the appointment of a registrar-historian. It will be her task to maintain contact with members and record their eventual choice of career following graduation from school.



# NURSING SERVICE

## Epidermoid Carcinoma

LILY WATANABE

WITH THE EXCEPTION of tuberculosis and heart disease, probably no other condition has been so widely publicized as cancer. The public has been made aware of the extreme importance of its early recognition if present methods of treatment are to be effective. While the medical profession cannot, as yet, promise a sure "cure," the very good results obtained through early and thorough excision of malignant tissue and judicious use of x-ray therapy are indicative of their value. The etiology of any form of carcinoma is also unknown although advances in research seem to be bringing us ever closer to the day when this mystery, too, will be solved. No age group is immune but we have come to associate certain forms of cancer with particular age ranges. One of these forms of malignancy is illustrated in the story of Rosemary.

Rosemary was a 28-year old woman of Lithuanian descent. She was employed as a waitress in a downtown cafe in a large city and seemed to enjoy her work. Although happily married, she and her husband lived apart — seeing each other about twice a year — since financial circumstances made it impossible for Rosemary to maintain a home near the air base where her husband was stationed. Fortunately, she possessed an emotionally stable and well-balanced personality since her home environment tended to be unpleasant. Rosemary

lived with her mother who seemed to lack both intelligence and understanding of her daughter's condition when she eventually became ill. Rosemary had average mental ability which, later, made it easier for her to comprehend and adjust to the outcome of her illness.

Although she had not suffered from the usual childhood diseases, Rosemary had some knowledge of illness and hospitalization. At various times she had suffered from jaundice, pleurisy and a bout of hematuria of unknown origin. As a child she had had appendectomy and tonsillectomy performed. She had also had one miscarriage, and several cervical cauterizations made necessary by periodic bouts of abnormal bleeding. Each cauterization had been followed by normal menstrual periods. Her present admission became necessary when she developed a continuous flow of vaginal discharge which extended over a period of a month. She had slight abdominal pain and intermittent bleeding associated with this discharge.

Her physical condition was normal apart from the abnormal discharge. Laboratory examination showed normal findings in regard to urinalysis and blood count with a negative Friedman test. To establish a definite diagnosis, a biopsy was indicated. At the time of biopsy, a tumor was discovered in the cervix and a cervicectomy was carried out. The specimen was sent for microscopic examination and the pathological report indicated the presence of epidermoid or squamous cell carcinoma — a malignancy arising from the flat squamous cells covering the vaginal part of the cervix. To be certain that all malignant cells

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Miss Watanabe, who was a student at Misericordia Hospital, Winnipeg, was awarded a book prize for her study which received the third highest mark in the Macmillan Nursing Care Study competition.

are removed a complete removal of the uterus and its surrounding glands is imperative. This was the next step in the treatment and care of this patient.

### PREOPERATIVE NURSING CARE

The nursing care of a patient begins as soon as she enters the hospital doors. The nurse is the person with whom she first comes in close contact and from whom the patient gains her first and lasting impressions. Any patient, regardless of previous admissions, enters hospital with certain qualms although she may be most adept in hiding them beneath a cloak of external casualness. Calmness, cheerfulness, self-confidence and friendliness in the nurse inspires confidence on the part of her patient as well as gaining her cooperation. Rosemary was oriented to the routine of the ward, settled comfortably into bed and introduced to her room-mates. During the first few days that she spent in hospital, she underwent various tests and had a biopsy performed, all of which were accompanied by the explanation and reassurance necessary to produce a relaxed patient.

Rosemary's preparation for operation was quite extensive. Her meal the evening before the day of operation was light. While it is most essential that food and fluid intake be adequate, particularly prior to surgery, it is equally important that the gastrointestinal tract should be relatively free of contents at operation to reduce postoperative nausea, vomiting, distention and flatulence. For the same reasons, the nurse administered a saline enema shortly prior to operation. Vaginal cleansing with dettol solution, shaving and thorough cleansing of the skin area in and around the operative site helped to minimize the possibilities of infection postoperatively.

Preparation for operation should never be considered complete until the patient has been prepared mentally. Rosemary was worried about her coming operation and her mother's unsympathetic attitude did little to help her. She was intelligent enough to understand that she was not to blame for her physical condition, contrary to her mother's accusations, but resented her mother and was very much upset by

her attitude. Rosemary had shown marked depression upon learning that she had a malignant condition and was subject to frequent crying spells. She was Roman Catholic by faith and a chat with the priest whom her husband had requested to see her helped substantially to put her mind at rest. Her doctor and her anesthetist visited her and explained the procedures which she would encounter in the operating room and the reason for the surgery. A good night's rest is most essential mentally and physically prior to surgery, so Rosemary was given morphine sulfate gr.  $\frac{1}{4}$  to help relax her and accomplish this requirement. It is an accepted fact that the patient who is both mentally and physically relaxed is a better operative risk and less disposed to the development of shock.

On the morning of operation, her vital signs were checked once more and she received seconal sodium gr.  $1\frac{1}{2}$  at 6:00 a.m. followed by morphine gr.  $\frac{1}{6}$  and atropine sulfate gr.  $\frac{1}{150}$  at 7:00 a.m. just before going to the operating room. The seconal sodium and morphine assisted in maintaining physical and mental relaxation, the atropine sulfate served to check excessive salivation and thus avoided possible atelectasis as well as assisting in minimizing postoperative nausea and vomiting. Rosemary's hairpins and jewellery were removed before she left her room, to prevent injury or loss while under anesthesia.

### SURGICAL REPORT

A Wertheim hysterectomy was carried out. This entailed removal of the uterus and pelvic node resection. The specimen was sent to the laboratory and the pathological report indicated that the malignant growth had invaded the parametrium, vaginal wall and the body of the uterus through the endocervical canal.

### POSTOPERATIVE NURSING CARE

Rosemary returned from the operating room under general anesthesia. Her condition was fair — blood pressure tended to be rather low, pulse and respirations rapid. An intravenous of 1000 cc. 5% glucose in distilled



water had been started in the operating room and was maintained on the ward with an additional 1000 cc. of 10% travert in normal saline. She was moved from the stretcher to a specially prepared recovery bed. Extra blankets were provided for additional warmth to help combat lowered body temperature. She was postured with her head turned to one side to prevent aspiration of mucus or vomitus. The airway was left in position until Rosemary reacted sufficiently to voluntarily expel it from her mouth. Leaving the airway in position restrains the tongue thus maintaining a free breathing passage. It must be remembered that under anesthesia voluntary control of the tongue is temporarily lost and it tends to drop back in the throat blocking the trachea.

The dressing over the wound was checked for any evidence of excess bleeding. Blood pressure, pulse and respiration rates were taken at regular intervals since changes in these readings may give the first signal of internal hemorrhage. As soon as Rosemary was conscious, the head of the bed was elevated so that she was in a semi-sitting position. This promoted drainage through the polyethylene tubing which had been inserted at the close of the operation to drain fluid and blood from the peritoneal cavity. This tube was opened at four hour intervals to allow the accumulation of fluid to escape. The nurse responsible for this used sterile equipment and aseptic technique to avoid the possibility of infection.

Crystalline penicillin, 1,000,000 units, was given every four hours for four days as a prophylactic measure. Morphine sulfate gr.  $\frac{1}{4}$  was also given every four hours, as necessary, to alleviate pain. Since pain is thought to be a predisposing factor in the development of shock, controlling it is important.

Rosemary was encouraged to move her legs freely as soon as she could cooperate following her operation. This is very useful in preventing circulatory disorders — in particular, femoral thrombosis. Deep breathing exercises maintained adequate lung expansion and helped to prevent pneumonia. A few days after surgery she developed a slight cough for which she was given

syrup cacillica compound drams 2, three times daily after meals and at bedtime. Early ambulation is an important factor in preventing postoperative circulatory disorders.

Rosemary sat on the edge of her bed and "dangled" her legs within 24 hours after her operation. On her fourth postoperative day she was allowed out of bed for a few minutes. She developed some discomfort from flatulence which was relieved successfully by the insertion of a rectal tube, and later, the administration of an enema containing magnesium sulfate, two ounces; glycerin, four ounces and water, six ounces. A mild laxative, magnolax, was given as needed during the remainder of her convalescence.

An indwelling catheter was placed in the bladder postoperatively. This avoided the danger of distention from a full bladder and possible disruption of the suture-line plus adding to the patient's general comfort. Pain at the site of operation, fear of pain, temporary loss of muscle tone due to anesthesia and operative handling or nervousness are all factors which may make it difficult for normal voiding to take place following an operation such as hysterectomy. Perineal care was given for the first few days postoperatively to add to Rosemary's comfort and further reduce the possibility of infection. The catheter was removed at the end of four days and the first normal voiding was noted and recorded as to time and amount.

Intake and output records were maintained immediately postoperatively to ensure that the patient received adequate amounts of fluid. This was essential from the point of view of fluid balance in the body and proper functioning of the urinary system.

Rosemary's convalescence was satisfactory and she was discharged two weeks after her operation. She will continue to convalesce at home until her physical condition permits her to return to her former work. With the help of her doctor and her husband, more satisfactory living arrangements have been made to allow her to rest and convalesce more effectively. Rosemary and her husband are looking forward to the adoption of a child to fill the place of the baby she cannot have herself.



# Salt-losing Nephritis

D. RICHARDS and R. DODKIN

THE TERM NEPHRITIS shields a number of conditions possessing such varied clinical signs that they really appear as unrelated diseases. Years of research have failed to throw much light on the nature of nephritis. It is known that the kidneys show changes in each of the conditions, appearing pale with scattered punctate hemorrhages in acute conditions, enlargement in chronic states, and becoming small, red and scarred in the late stages. Salt-losing nephritis is one of the members of this diverse family. This discussion centres around John More who developed salt-losing nephritis when he was 39 years old.

At the age of 18, Mr. More had an attack of nephritis from which he made an apparently complete recovery within a short time. This demonstrates a few of the interesting facts about nephritis. It most often affects young persons, especially children, and males are much more susceptible to this condition than females. Over 95 per cent of the patients recover completely within a few days, although in some cases a period of months may elapse before recovery is accomplished. If recovery is complete, recurrence is rarely seen. In Mr. More's case recovery would seem to have been complete since he had no further difficulty for a period of over 20 years.

Early in 1955, Mr. More developed an illness during which he became quite jaundiced. From his personal history it was felt that he probably had had an attack of infectious hepatitis since another member of the family was ill with this condition at the time. Again recovery was uneventful and Mr. More returned to work. However, a few months later, he developed a dark red, blotchy rash on his arms and legs. His doctor placed him on antihistamine therapy with no apparent improvement. Mr. More was referred to a skin specialist who placed him

on cortisone therapy and the rash disappeared. Unfortunately he developed a gastroenteritis with diarrhea one week later which he blamed upon the "doctor's pills." Upon admission to hospital at this time Mr. More exhibited abdominal distention with some type of obstruction which caused him severe pain. Blood chemistry indicated abnormalities in the amylase, thymol and zinc tests. An absence of ester-cholesterol which was thought to indicate severe liver damage, was also demonstrated.

Pancreatitis was considered as a possible diagnosis but clinical tests ruled it out. Since Mr. More's symptoms were becoming increasingly severe he was finally transferred to the Sarnia General Hospital for further investigation and treatment. Here gastric suction was established and fluid balance was maintained by intravenous therapy. His blood pressure and urea levels were found to be normal. The cause of the abdominal pain could not be determined exactly but acute cholecystitis was suspected and an operation was considered.

The laboratory director suggested that Mr. More's condition might be of a toxic nature and gave *Canicola fever* as a tentative diagnosis. This is a disease transmitted by dogs or rodents. It tends to produce abdominal pain, slight jaundice, an elevated white blood count and severe liver and kidney damage. As a result, operation was withheld and a lengthy investigation conducted at the end of which Mr. More's blood was found to be negative for *Canicola fever*. He gradually improved and was discharged from hospital. Several weeks later Mr. More had a dental extraction performed and subsequently became extremely ill. He was admitted to hospital where a diagnosis of *salt-losing nephritis* was made.

## SIGNS AND SYMPTOMS

Mr. More complained of headache, the loss of sight in his left eye and

Mrs. Richards and Mrs. Dodkin presented the material in this paper in a clinic at the Sarnia General Hospital.

dyspnea. He exhibited fever, an elevated blood pressure, severe albuminuria, low blood urea and sodium content, and mental confusion. He was found to have left ventricular heart failure in addition. Both lungs contained a great deal of fluid and Mr. More had considerable discomfort from abdominal pain and distention. It was felt that he might have developed *periarteritis nodosa* — a disease characterized by abdominal pain in some instances, fever, weakness and cardiovascular disorders and which produces inflammatory and degenerative changes in blood vessels. In this instance Mr. More had a kidney infarction which accounted largely for the changes in his blood chemistry.

#### TREATMENT

Intravenous therapy with ansolysen was instituted to help reduce Mr. More's elevated blood pressure. It dropped from 220/152 to 142/128. Thoracentesis was performed to free the lungs of their accumulation of fluid and to facilitate breathing. Hydrocortisone was given since this preparation has been found to produce very good results in the treatment of *periarteritis nodosa*. It is preferred to cortisone since there is less disturbance of potassium and sodium levels.

Demerol and largactil diminished

the pain and restlessness while oxygen therapy and aminophylline alleviated the dyspnea produced by the left ventricular heart failure. Regular insulin was added to the intravenous solution since Mr. More's potassium levels were high. The insulin combined with the sugar and potassium thereby reducing the amount of the latter in the blood stream. Electrolyte balance was maintained with specially prepared intravenous fluid and plasma. Penicillin 500,000 units was given twice daily prophylactically. It will be noted that all medications were given by other routes than the oral one since Mr. More could not take anything by mouth.

#### PATHOLOGY

It was very difficult to determine the exact diagnosis of Mr. More's condition. Terminal nephritis induced by the dental extraction or malignant hypertension were both possibilities. *Periarteritis nodosa* was thought to be definitely associated. The first two conditions invariably have a fatal outcome, the latter usually yields to therapy with hydrocortisone. Unfortunately the outcome in this case was fatal and upon post mortem examination it was discovered that Mr. More had suffered from 1) chronic nephritis and 2) *periarteritis nodosa*.

## Victorian Order of Nurses

The following are staff changes in the Victorian Order of Nurses for Canada:

**Appointments** — Burnaby, B.C.: *Mrs. Moira Thomson* (St. Paul's Hosp., Vancouver). Hamilton: *Joan Tournay* (Toronto Gen. Hosp.). Lachine, P.Q.: *Christina Brunott* (St. Francis Hosp., Holland). Lincoln-St. Catharines: *Sheila Malcowski* (Halifax Gen. Hosp.). Montreal: *Gayle Lightbody* (McMaster Univ.) and *Doreen Sawyer* (Montreal Gen. Hosp.). Preston, Ont.: *Mrs. Clara Weaver* (St. Mary's Hosp., Kitchener). Surrey, B.C.: *Mrs. Eileen Kelly* (Vancouver Gen. Hosp.) and *Mrs. Jean Maltby* (Soldiers' Memorial Hosp., Campbellton, N.B.). Saskatoon: *Mrs. Ruth Mullie* (St. Paul's Hosp., Saskatoon). Toronto: *Joan Van Nest* (St. Jos.

Hosp., Toronto). Vancouver: *Hilda Evans* (North Staffs Royal Infirmary, Eng.), *Mrs. Donna Mort* and *Mrs. Vivian Yoder* (Vancouver Gen. Hosp.). Victoria: *Mrs. Mabel Lassen* (Royal Alex. Hosp., Edmonton) and *Jean MacDonald* (Hamilton Memorial Hosp., N. Sydney, N.S.).

**Transfers** — *Phyllis Farmer* to Regina, nurse-in-charge; *Mrs. Maude Grant* to Liverpool, N.S.; *Roberta Greig* to Surrey; *Grace Hill* to Trail, nurse-in-charge; *Margorie Joyce* to Medicine Hat, nurse-in-charge; *Amy Keown* to Weston, Ont.; *Margaret McRae* to Lunenburg, N.S.; *Helen Servage* to Pembroke, nurse-in-charge; *Gloria Somerville* to Toronto; *Marion Van Noort* to Kentville, N.S. nurse-in-charge; *Mrs. Joan Wellum* to Hamilton.



# Schizophrénie

SOEUR LOUIS-ETIENNE f.a.s.p.

## HISTOIRE PERSONNELLE

*Mme Roy:* Canadienne-française, catholique, âgée de 32 ans, était admise à l'hôpital en janvier 1952. Née en 1922, troisième d'une famille de cinq enfants. Naissance et développement normaux.

*Antécédents physiques:* Maladies en bas âge: rougeole, coqueluche, scarlatine, amygdalectomie (8 ans). Sub-hystérectomie à 28 ans.

*Scolarité:* A six ans, placée au couvent, à titre de pensionnaire, elle se sent rejetée, bien qu'elle eut là deux tantes religieuses qui furent d'une grande bonté et essayèrent par tous les moyens de la gâter. Elle ne put jamais chasser cette idée fixe: "Maman ne m'aime pas puisqu'elle m'a placée ici et qu'elle garde ma soeur à la maison." Dès ce moment, elle dit ne jamais avoir eu de bonheur, ni goût aux jeux, aux récréations, à l'étude, etc. Elle commença dès lors à être soupçonneuse et jongleuse, se tenant plutôt à l'écart. Son sentiment d'être rejetée l'empêcha de donner son attention à l'enseignement. Etant intelligente, elle réussit en dépit de son conflit. Elle quitta l'école à cause de la maladie de son père et commença à travailler à 14 ans.

*Travail:* Premier emploi dans une buanderie: trois mois. Après elle entra dans une manufacture de fourrures et y travailla six ans.

## MILIEU FAMILIAL

*Mère:* Personne autoritaire et surprotectrice à la fois, qui dépensait une grande activité pour le confort des enfants et l'entretien de la maison, tout en maintenant une atmosphère de malaise par ses récriminations à son mari et ses recommandations et reproches à ses enfants. Elle affichait une piété intempestive, pratiquait force dévotions extérieures, obligeant la famille à l'imi-

ter, ce qui porta plutôt à s'éloigner de la religion et suscita maintes discussions.

Elle parlait beaucoup, énumérait à qui voulait l'entendre tout le bien qu'elle avait fait pour les siens; elle affirmait n'avoir rien à se reprocher et n'être nullement responsable si ses enfants n'étaient pas ce qu'ils devaient être. En somme, elle cherchait à se disculper.

*Père:* Maître de poste, homme sobre, intelligent, bon pour ses employés, mais qui fréquentait peu ses proches. Avait subi l'influence de son épouse, demeurait passif devant l'autorité de cette dernière. Décédait d'urémie en 1948. La patiente était plus attachée à son père qu'à sa mère.

Il est évident que tous les membres de cette famille vécurent les uns les autres dans un état de friction, de contradictions, de disputes et malaise, ce qui les poussait à quitter le toit familial à la première occasion. La patiente rapporte qu'auprès son travail, elle aurait voulu accomplir certaines tâches et que la mère s'interposait donnant comme raison qu'elle avait assez du travail à l'atelier; par ailleurs elle ne cessait ses réprimandes pour tout et rien.

*Religion:* A 17 ans, elle ne pratiquait plus. Vers la même époque son patron la menaçait de perdre son emploi si elle refusait ses avances; cette situation augmenta grandement ses difficultés intérieures. Son père mourut alors. Cette peine la porta à se replier sur elle-même et elle vécut un épisode de dépression. Elle relate: "Durant trois ans, je ne m'habillais que de noir, symbole de mon âme en détresse; j'avais perdu le goût de la vie."

*Mariage:* A 18 ans, un garçon lui inspira confiance, la fréquenta deux ans et l'épousa. Elle dit ne pas l'avoir aimé, mais avoir joui d'un sentiment de sécurité. D'ailleurs, c'était une bonne occasion pour fuir le toit familial. L'adaptation conjugale fut très pénible et laissa un souvenir désagréable à la patiente. Trois semaines

Soeur Louis-Etienne est une infirmière psychiatrique à l'Hôpital Saint-Jean-de-Dieu, Montréal.



après, son mari commença à la déserter. Il était vraisemblablement alcoolique et infidèle, ce qui porta Mme Roy à croire qu'elle n'était pas pour lui une véritable épouse et qu'à ses yeux, elle ne valait pas plus que la première femme qu'il eut rencontrée sur la route. Elle eut voulu qu'il aime assez pour en être jaloux. Elle croit que ce sentiment motiva la reprise de ses entrevues avec son ancien patron. Quand son mari lui manifestait quelques délicatesses, elle se sentait très coupable.

#### DÉBUT DE LA MALADIE

A cette époque, elle devint enceinte. Elle se voyait incapable de briser sa liaison et sembla de plus en plus déprimée. A la fin de sa grossesse elle promit que si son enfant naissait en bonne santé, elle romprait coûte que coûte, ce qu'elle fit d'ailleurs.

Après la naissance de son fils, elle manifesta des troubles de comportement, accepta mal le surcroît de travail occasionné par celui-ci, et détesta de plus en plus le travail de maison. Malgré tout, elle se consacra à son enfant, avec l'idée constante qu'elle le laisserait pousser à sa guise sans contrainte, se rappelant toutes les frustrations dont elle avait souffert elle-même.

Elle essaya de combattre l'anxiété grandissante en fumant énormément et en faisant usage de somnifères, mais les symptômes s'installèrent graduellement. Elle consulta médecin après médecin pour divers symptômes, dans le but d'obtenir des calmants. Elle ne renouvelait jamais une première visite. Elle passait plusieurs jours sans manger pour se gaver les jours suivants. Elle buvait du thé exagérément. Elle fit des périodes d'agitation. S'enfuyait chez un membre de sa famille (mère-frère-soeur). A la maison, restait couchée, ne préparait pas les repas ni ne nettoyait la maison. La nuit, elle chantait à tue-tête. Elle menaçait son mari.

Elle tenta d'empoisonner son enfant de quatre ans avec des somnifères. Disait qu'elle voulait le faire disparaître pour le soustraire à toutes les misères qu'elle avait subies elle-même. Ajouta qu'à sa prochaine tentative, elle ne manquerait pas son coup. Traitée à deux reprises dans une clinique psy-

chiatrique, elle resta au plus trois semaines, et s'opposa à tous les traitements. Elle fut envoyée dans un hôpital psychiatrique sur l'avis d'un psychiatre qui la trouva dangereuse pour elle-même et son entourage.

#### EVOLUTION DE LA PSYCHOSE

A son admission : Difficile, se plaint qu'on la détient injustement ; dit qu'elle ne veut plus vivre avec son mari, à l'avenir, mais bien comme elle l'entendra :

Agitée — sans sommeil ;

Hautaine — arrogante ;

Tient des discours bizarres et incohérents ;

Sens de l'auto-critique nul ;

Croit que ses parents sont contre elle, etc.

*Diagnostic :* Après les examens et observations de routine, l'assemblée médicale pose un diagnostic de : Schizophrénie (Type Schizoaffectif) et Mme Roy est dirigée dans une salle de traitements.

*Traitements :* Sédatifs, pour calmer l'agitation et l'insomnie ; Electrochoc-thérapie ; neuf traitements sans succès.

Après une certaine période, la thérapie convulsive fut reprise et cette fois, au cinquième traitement, la patiente s'étant améliorée, le médecin prescrivit de l'occupation thérapeutique sous forme de travail domestique à la résidence des infirmières, donc en dehors de son département.

*Tentative de suicide :* Un matin à son travail entendant sonner le téléphone, elle croit que c'est pour la faire venir à son département pour recevoir un électrochoc, elle se jette en bas du troisième étage dans le but de s'infliger une blessure qui l'empêcherait d'avoir son traitement. Il en résulte une fracture. Elle explique cependant qu'elle n'a pas le désir de se supprimer.

Remise de cet état, son comportement se maintient plus calme, et elle obtient un congé de 15 jours qu'elle passe chez son frère. A son retour, interrogée par le médecin, elle affirme toujours désirer tuer son enfant qu'elle dit aimer. "J'ai été élevée de telle façon, mon enfant me ressemble, je me déteste et déteste en mon enfant ce qui me ressemble." Devient plus activement délirante par la suite. S'évade la nuit, dit qu'elle ne veut pas mourir

seule. Voit des signes. Partout, essaie de nouer des intrigues sentimentales. Croit qu'on veut l'empoisonner. Se sent poursuivre.

Veut tuer son enfant et pour cela écrit au médecin lui disant avec force détails, ses projets qui se résument à ceci :

Solliciter la faveur de sortir afin de tuer mon enfant en lui assénant un coup, qui ne parviendrait pas à lui donner la mort instantanément mais que, conduit à l'hôpital, on serait impuissant à lui sauver la vie; elle voulait qu'il reçut tous les sédatifs nécessaires à lui supprimer ses douleurs. Durant ce temps, elle reviendrait à l'hôpital psychiatrique sans protester, attendant la nouvelle de la mort de son enfant. Elle croirait à cette mort seulement lorsqu'une photo le représentant dans sa tombe, lui serait remise, etc. Alors, elle aurait la "paix du coeur."

Cette lettre provoque chez les autorités médicales la décision de la changer de département où elle serait plus étroitement surveillée.

*Amélioration:* Ce changement de département joua un rôle très important dans la vie de cette malade. De cette époque les symptômes déclinerent pour faire place à un comportement prometteur de guérison.

A son arrivée dans ce département, la patiente semblait à ce point atterrée, que le personnel s'en émut et redoubla de sympathie. Le contact s'établit dès les premiers moments et le transfert positif avec le médecin et l'hospitalière fut immédiatement établi. Utilisant ce critère, le médecin traitant de cette unité traça au personnel une ligne de conduite; lui-même accorda à la patiente de multiples entrevues où il appliqua une technique de psychothérapie intensive. Il s'agissait de redonner à cette personne l'amour et le respect d'elle-même et cela en lui en donnant beaucoup de la part de ceux qui l'entouraient.

Etant défiante à l'extrême et ne croyant à la sincérité de personne, il fallait toujours lui dire la vérité, et obtenir sa confiance. Le personnel lui témoigna un attachement réel qui finit par la convaincre qu'elle n'était pas si détestable puisqu'on pouvait l'aimer encore. Durant les premières semaines,

la patiente continua d'écrire ses idées délirantes à sa mère. Petit à petit, Mme Roy se confia plus librement à l'hospitalière et aux infirmières.

#### PROGRAMME DE RÉHABILITATION

On la dirigea vers l'occupation thérapeutique du département même. Elle accepta de confectionner des vêtements et accessoires de toilette pour elle-même. Elle éprouva une vive satisfaction dans la réussite de ces choses et était joyeuse de les montrer à sa famille, insistant sur le fait qu'on lui avait "donné" le matériel à l'hôpital, par conséquent, on lui portait de l'intérêt. Durant les entretiens, on lui laissait aborder ses propos bizarres et délirants, finalement elle en vint à juger elle-même de l'anormalité de vouloir tuer son enfant.

Au département, le programme d'activité suivait sa marche avec succès. De solitaire et incapable de communiquer avec les autres qu'elle était, elle devint de plus en plus sociable. Elle organisa des fêtes avec ses compagnes pour d'autres compagnes et fit des "surprise parties" pour le personnel, afin de suivre la tradition de ce département qui voulait qu'on marqua d'une réunion joyeuse, les anniversaires et les événements importants.

Ses tendances paranoïdes furent canalisées vers un but altruiste et son talent servit à composer chansons, rimes, adresses, compliments pour ces occasions. Sa bonne volonté et sa facilité à faire plaisir même aux plus dépourvues, aida à l'atmosphère thérapeutique de tout le département, plus d'une malade bénéficia de son influence. Elle collabora aussi au journal de l'hôpital et envoya dans un article, la description d'une réunion où elle avait prêté son concours.

Devant ces progrès, il fut décidé qu'elle visiterait son fils de temps à autre, accompagnée. Tout se passa de la manière la plus normale. De retour à l'hôpital elle discuta sensément du problème avec le psychiatre, il devint évident que le désir de tuer son enfant était disparu.

Elle dominait son besoin de rêverie par des distractions qu'elle réclamait dès qu'elle se sentait livrée à elle-même. Durant les entretiens, elle reconnut le besoin de dépendance qu'elle



éprouvait vis-à-vis de sa mère. Elle lutta pour s'affranchir de ce besoin et y réussit, ce qui fut pour la patiente une véritable révélation. Elle éprouva beaucoup de détente à se trouver libérée.

*Attitude des siens:* Durant ses sorties et au cours des visites de sa mère, celle-ci qui tentait encore de l'accaparer, fut surprise de voir Mme Roy prendre le dessus et ne pas céder dans les choses d'ordre ordinaire. La patiente de dire "je veux l'habituer graduellement, afin que, retournée dans mon milieu, je me sente libre d'agir. Si je suis trop douce maintenant, et m'affirme à ma sortie, on peut croire à une crise de colère ou à une rechute." Son mari assistait de loin à cette cure, voulait en douter, ne manifestait aucun encouragement à la patiente, souhaitant même visiblement une rechute. Frères: S'intéressaient visiblement à elle. L'ainé accepta de la recevoir et s'en rendit responsable quand le congé signé, elle partit de l'hôpital.

#### ADAPTATION À L'EXTÉRIEUR

Elle alla vivre chez son frère, bientôt sa belle-sœur accepta mal sa présence. Elle trouva un emploi dans un atelier de fourrures, démenagea et organisa sa vie dans une chambre louée. Elle équilibra bien son budget, se tira parfaitement d'affaires, même si elle connut des difficultés. Son mari ne voulut pas reprendre la vie commune, essaya de l'interdire, elle s'opposa et obtint de la cour que la curatelle soit donnée à son frère; malgré tous ces tracasseries, elle ne développa aucune anxiété.

A son départ de l'hôpital, il fut entendu que son fils resterait aux soins

de sa grand-mère paternelle et de son père. Elle consentit même à cet accord malgré la désir fréquent de le revoir; elle communiqua avec lui sous forme de colis qu'elle lui envoya de temps à autre. Elle sait que pour le moment cette situation est la meilleure, ne se sentant pas encore prête à reprendre cette responsabilité, elle réserve son énergie mentale pour plus tard, où elle espère lui donner un foyer harmonieux.

Visite l'hôpital assez souvent, garde des rapports cordiaux avec le personnel et le service social. Toujours, elle manifeste le goût de vivre, le désir de lutter pour sa subsistance et son équilibre. Elle a repris ses pratiques religieuses abandonnées depuis longtemps et mène une existence saine et rangée.

#### RÉSUMÉ

Voici donc une personne dont l'incompréhension du milieu, aussi bien dans l'enfance que dans la vie d'épouse, apporta une détérioration de la personnalité au point de l'hospitaliser pour schizophrénie à la suite d'une tentative d'empoisonner son fils. Une technique sûre, suivie, menée par une équipe psychiatrique, combattit un à un chaque symptôme, pour aboutir à une resocialisation complète et un ajustement social aux problèmes suscités, lesquels furent maintenus même lorsque la patiente guérie, dut refaire une vie dans laquelle le mari déclinait ses responsabilités et essayait même de provoquer une faillite. Exemple encourageant d'un traitement de trois années apportant une récompense au-delà de toute attente.

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Knowledge of the processes behind Migraine is gradually accumulating. The basic cause seems to be a constitutionally abnormal reaction to the release of histamine into the bloodstream. The several types of migraine apparently represent variant reactions of the external carotid artery to the released histamine. It is important to determine the form of the disease present in each individual before attempting treatment.

As far as treatment is concerned the

priority of alleviation of the pain of the acute attack is emphasized. Simple analgesics, vasoconstrictors and vasodilators may provide this relief, sometimes dramatically. The next logical step is an attempt to prevent future attacks or at least decrease their frequency. The role of food allergy should not be overlooked. The migraine patient would do well to keep a dietary diary.

— *Scope Weekly*



# Nursing Profiles

**Annie Black Boyd, R.R.C.**, is now the director of public health nursing service with the Department of Health in Hamilton, Ontario. Excepting for her six years' leave of absence for service with the R.C.A.M.C. in World War II, Miss Boyd has faithfully served the citizens of Hamilton ever since her discharge from the army nursing service following World War I.

Very shortly after she graduated from Hamilton General Hospital in 1915, Miss Boyd went overseas with the C.A.M.C. She was awarded the Royal Red Cross, second class, after her years of service at base hospitals in France. Five years after she had joined the public health nursing staff in Hamilton Miss Boyd became a supervisor. She received the R.R.C. first class in recognition of her leadership as principal matron on the hospital ship *Letitia* during World War II.

Miss Boyd has been president of her own hospital alumnae association and also of District 4 of the Registered Nurses' Association of Ontario. She revels in the feel of the good earth as she tends her garden and enjoys equally making movies.



ANNIE BLACK BOYD

**Sister Mary de Loyola, F.C.S.P.**, who was named director of nursing at St. Paul's Hospital, Vancouver, in October 1955, has had ample opportunity to polish up her bilingual skill as she has moved from east to west in various hospital positions. She began her nursing training at Hotel-Dieu,

Montreal, then transferred to St. Jean de Dieu Hospital when she joined the Sisters of Providence in 1927. Her first graduate posting was as director of nursing at the hospital in Rivière du Loup, Que. Her first acquaintance with St. Paul's came in 1936 when she was made the supervisor of the medical floor there. Seven years later she was named superior of Notre Dame Hospital, North Battleford, Sask. During her term as administrator, the hospital was enlarged by the addition of a new wing to accommodate another hundred patients.

Transferred to Hôpital du Sacré-Coeur, Cartierville, as superior in 1949, Sister was responsible for the management of one of the largest hospitals in the Montreal area. It was during her regime there that she became a member of the American College of Hospital Administrators.



SR. MARY DE LOYOLA

**Barbara Joan Small** has taken up her duties as superintendent of nurses at the Manitoba School for the Mentally Retarded at Portage la Prairie, Man. A graduate of Winnipeg General Hospital, Miss Small has many avenues of interest that fit her well for her new work, in addition to her nursing background. She has musical training — both vocal and piano. She has been active in work with young people through her church affiliation. Previously Miss Small was engaged as a head nurse on the men's sur-

gical ward at W.G.H., then on the staff of the Hudson Bay Mining and Smelting Company Hospital at Flin Flon.



BARBARA JOAN SMALL

**Dorothy Marcellus** was appointed, early this year, to an exceedingly interesting piece of work under the auspices of the Ontario Society for Crippled Children. She is now assistant to Dr. H. O. Steer of the University of Toronto in the Cerebral Palsy Research Project which includes a study of the psychological aspects of the condition including the social, emotional and intellectual development of the affected children.

A graduate of the Toronto General Hospital, Miss Marcellus was on the operating room staff there for three years followed



(Skilling-Toronto)

DOROTHY MARCELLUS

by a period of duty as assistant night supervisor. Distant fields called and for eighteen months she was in South America with the Imperial Oil Company. Private nursing kept her busy for five years following her return to Canada; then she went back to T.G.H. as head nurse in the fracture room in the Department of Radiology.

In the summer of 1949, Miss Marcellus joined the nursing staff of the Ontario Society for Crippled Children as superintendent of Wooden Cerebral Palsy Centre, just outside London. Since that time she has devoted all her professional activity to the intensely engrossing work of the Mobile Unit of O.S.C.C. This unit has conducted a screening and diagnostic clinic for cerebral palsy, together with an assessment and parent instruction program, in various parts of Ontario. Having pioneered in the cerebral palsy program, Miss Marcellus is now one of the best informed nurses on this topic in Canada. Her new work will be watched with great interest.



MURIEL JEAN GRAHAM

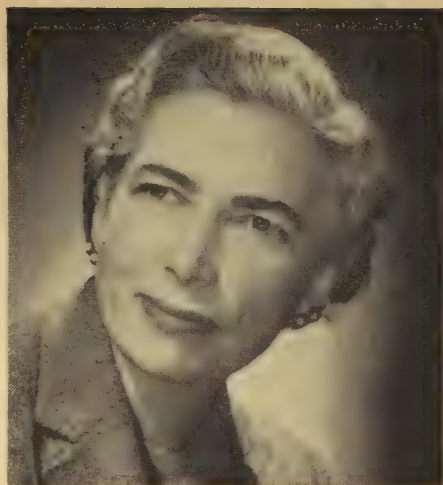
**Muriel Jean Graham**, who is the director of the School for Nursing Assistants, Camp Hill D.V.A. Hospital, Halifax, has had a wide variety of exciting professional roles since she graduated from Victoria General Hospital, Halifax, some 24 years ago. Her first assignment was as registrar and executive secretary with the Registered Nurses' Association of Nova Scotia. She relinquished this post to enlist with the R.C.A.M.C., serving overseas 1941-45. She was chosen as a nursing consultant with UNRRA and worked in China for two years. A less demanding interlude followed during which



she was educational director and assistant superintendent of nurses in the Children's Hospital, Halifax. Again the tide of events swept her away to new challenges as a nursing instructor in a WHO assignment to Rangoon, Burma. She returned to Halifax in 1954 and served as director of nursing at Children's until she assumed her present duties.

**Helen Neil McCallum** is initiating a new program for the Nursing Branch of the Ontario Department of Health as its first consultant in hospital nursing service. A graduate of the Hospital for Sick Children, Toronto, and holding her certificate from the University of Toronto School of Nursing in nursing education and administration, Miss McCallum has had many years of hospital experience as background for her consultative duties. She served as a head nurse at the Montreal Children's Hospital for some time before returning to her own hospital as assistant night supervisor. For the past six years she has been senior clinical instructor at HSC following ten years as medical supervisor. Among her hobbies, Miss McCallum lists a love to travel. There is no doubt that she will have ample scope for this urge in her new work.

**Helen Christena Wilson** has retired from active nursing after more than thirty



(Peggy Todd-Toronto)

## HELEN NEIL MCCALLUM

years of service, much of it in her own school of nursing, the General Hospital, Cornwall, Ont. Staff nurse then x-ray supervisor, Miss Wilson became director of nursing there in 1938. Seven years later she accepted a similar position at Soldier's Memorial Hospital, Campbellton, N.B. She returned to Ontario and served as superintendent of Winchester District Memorial Hospital until her retirement. She now resides at Lunenburg, Ont.

## In Memoriam

**Mary Gretchen Allison**, who graduated from Royal Victoria Hospital, Montreal, in 1920, died on April 17, 1956. She had engaged in private nursing during her active professional life.

\* \* \*

**Alma Douglas**, who graduated from the General Hospital, Woodstock, Ont., in 1919 died recently at Toronto.

\* \* \*

**Hilda May Dyer**, a member of the first class to graduate from the General Hospital, Swift Current, Sask., died at Victoria on February 29, 1956. Miss Dyer had worked continuously in the Swift Current area, engaging in staff or private nursing, until her retirement in 1952.

\* \* \*

**Annie M. Forrest**, who graduated from Winnipeg General Hospital in 1907, died on April 4, 1956 at the age of 81. Miss Forrest served overseas during World War I. She

was superintendent of nursing at the Queen Alexandra Sanatorium in London, Ont., for many years prior to her retirement in 1933.

\* \* \*

**Margaret Ann Gavin** died at Brockville, Ont., on April 4, 1956 at the age of 86. Active in nursing in the Brockville area, Miss Gavin had been retired for many years.

\* \* \*

**Mary Goldhawk** died at London, Ont., on April 29, 1956. Until a very short time before her death Miss Goldhawk was a plant nurse with The Canadian Bridge Company at Walkerville, Ont.

\* \* \*

**Sarah Annie Le Good**, who graduated from St. Boniface Hospital in 1923, died at Souris, Man., on February 15, 1956 after an illness lasting 15 years. She was 56 years of age.

\* \* \*

**Grace McKeever**, who graduated from



Winnipeg General Hospital in 1921, died there suddenly on April 15, 1956. Miss McKeever was formerly superintendent of nurses at Manitoba School, Portage la Prairie.

\* \* \*

**Bertha Lynetta Mallory**, a graduate from Ogdensburg, N.Y., died at Caintown, Ont., on February 18, 1956, in her 67th year.

\* \* \*

**Mary Elizabeth Moody**, a graduate of New York General Hospital, died at Huntington, Que., on February 21, 1956, following a long illness.

**Céline Moore**, who graduated from Hôpital St. Luc, Quebec, in 1931, died on March 3, 1956 at Ste. Marie de Beauce. She was formerly on the staff of the hospital at Ste. Anne de Bellevue.

\* \* \*

**Helen L. (Sheldon) Poetschke**, who graduated in 1930 from the University of Alberta Hospital, Edmonton, died on September 9, 1955.

\* \* \*

**B. (Collier) Smith**, who graduated in 1908 from Medicine Hat General Hospital, died on September 20, 1955.

## Sélection

### *Une innovation qui pourrait réduire les coûts de construction des hôpitaux.*

IL EST POSSIBLE QU'EN CONSTRUISANT SON nouvel hôpital général de 250 lits, la ville de Niagara Falls (Ont.) ait trouvé un moyen de diminuer les coûts toujours croissants de l'hospitalisation.

D'une conception nouvelle, l'hôpital comprend un immeuble central de trois étages et des ailes moins coûteuses d'un seul étage. On estime que la grande efficacité de l'immeuble à plusieurs étages de l'hôpital conventionnel n'est pas nécessaire dans le cas de la majorité des malades qui, une fois le stage critique de leur maladie passé, peuvent être soignés dans une aile moins coûteuse de convalescence. On prévoit que cette idée entraînera une économie d'environ \$3,000 par lit dans le coût général de la construction.

En outre, le transfert du malade à l'atmosphère d'optimisme de l'aile de convalescence peut réduire la durée du stage à l'hôpital et, partant, les coûts qu'il entraîne. Extrait de la *Gazette du Travail*, février 1956.

### *Les méfaits du bruit et leurs répercussions sur l'organisme humain.*

Les médecins ont présenté, devant l'Académie Nationale de Médecine de Paris, un exposé très précis sur les méfaits du bruit et leurs répercussions sur l'organisme humain.

Les auteurs, après avoir rappelé quelques notions fondamentales relatives aux diverses modalités d'action du bruit et des vibrations, montrant comment, en affectant l'appareil auditif et par-delà l'oreille, le cerveau et le système nerveux, cette action provoque des chocs, des traumatismes cérébraux et des

réflexes émotifs qui se répercutent singulièrement sur la santé des humains.

Des troubles, des manifestations pathologiques et même certaines affections organiques peuvent apparaître ou s'aggraver sous l'influence du bruit et des trépidations et les auteurs citent des exemples.

Il s'ensuit que, médicalement, une lutte opiniâtre doit être menée contre "ce nouveau danger social."

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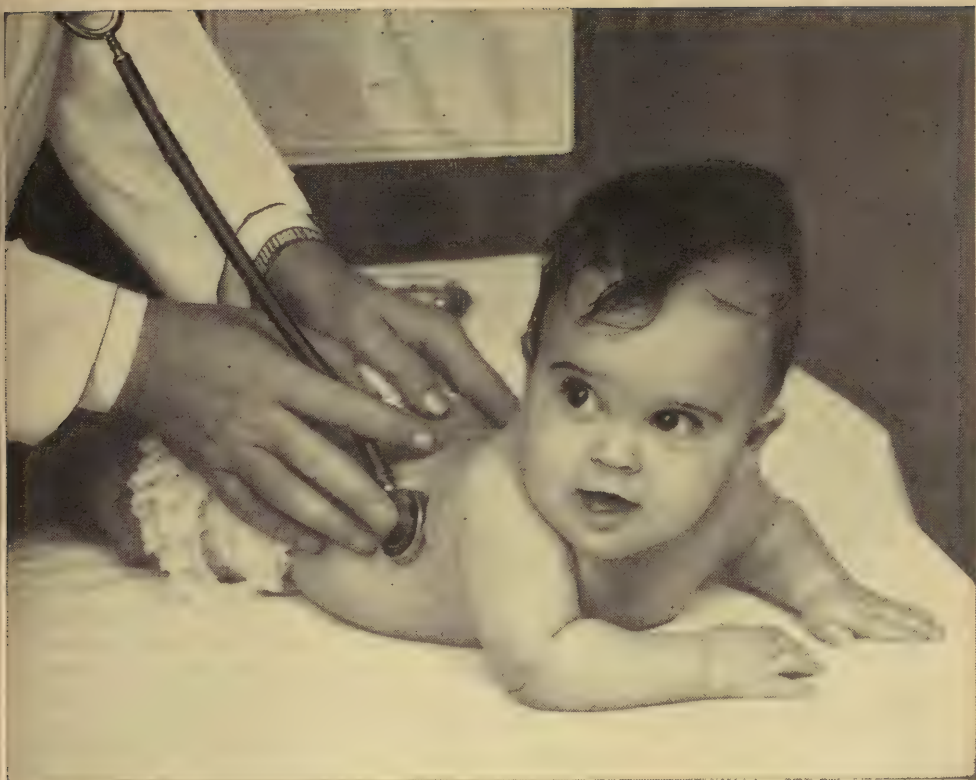
Extrait de *Information médicale et para médicale*, de Montréal.

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A new treatment has been developed for patients with liver disease who become mentally confused or stuporous and show symptoms of impending coma. Hepatic coma has long been a confusing syndrome. It occurs suddenly — the patient becoming unduly drowsy and speaking with slurred or thick speech. A period of noisy confusion and delirium is followed by unconsciousness.

In certain patients this chain of events can be broken by L-glumatic acid. These are people (chronic alcoholics for the most part) in whom hepatic coma is precipitated by a high protein diet, treatment with a diuretic or sudden gastrointestinal bleeding. The badly damaged liver cannot stand the additional strain and the individual becomes confused and disoriented. The same drug also produces good results in the cirrhotic patient who shows definite but mild neurological symptoms over an extended period without improving or regressing into permanent coma. Under such circumstances normal mental status has been consistently restored.

— COMMUNICATIONS ASSOCIATES



## “Better physical condition when fed meat early . . .”

**I**N a study conducted by Leverton and Clark “Meat in the Diet of Young Infants”, (J. A. M. A., 134,1215 (1947), special prepared meat was added to the formula of full-term babies beginning at the age of six weeks and continuing for a period of eight weeks. The pediatrician in charge considered that the babies were in better physical condition generally as a result of the meat supplement. Nurses in attendance reported that the meat-fed infants seemed better satisfied, slept well and cried little.

*Swift's Meats for Babies was the original product of this kind placed on the market. Prepared from only fine, lean meat, the food is*

*cooked and milled to a fine purée. The texture is soft, moist and easily fed in formula or for initial spoon feeding just as it comes from the can. There are seven kinds for variety and special conditions: Beef, Lamb, Pork, Veal, Liver, Heart, Liver and Bacon, and also Swift's Egg Yolks for Babies, Salmon Seafood for Babies and the chopped Swift's Meats for Juniors.*

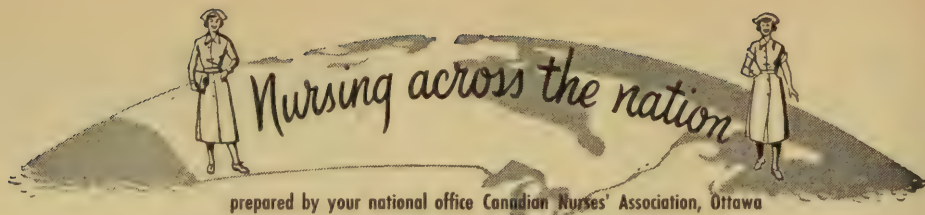
**Meats for Babies**  
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## *Nursing Progress in 1955*

SEVERAL MONTHS AGO we mentioned in this column that the CNA had been asked to submit a contribution for *The Yearbook of Modern Nursing* published by G. P. Putnam's Sons, New York. Early in May, we received a copy of this book in National Office. A collection of contributions from representatives of leading nurses' organizations, national and international, it gives a valuable, up-to-date picture of nursing events over the past year.

Important unpublished papers used in conferences, workshops and panel discussions are also included. Its pages are crammed full of important information about nursing in 1955. The price is \$4.95, the Canadian publisher is McAinsh & Co. Ltd., Toronto.

## *Canadians Abroad*

In May, two well-known Canadian nurses were in Geneva attending the 9th World Health Assembly. Attending as official nurse representative in the Canadian delegation was Miss Dorothy Percy, chief nursing consultant, Department of National Health and Welfare. Those fortunate enough to attend the Biennial Meeting will recall hearing Miss Percy speak of the Technical Discussions on *Nurses: Their Education and Role in Health Programs*.

Also present was Miss Alice Wright, executive secretary and registrar of the R.N.A.B.C. Earlier in May Miss Wright attended a meeting of the ICN Membership Committee in Copenhagen. Following this she visited nursing associations in Great Britain, Holland, Belgium and Germany.

## *Diversified Audience*

The CNA brief to the Royal Commission on the Economic Future of

Canada is having wide distribution. One hundred and seventy-five copies have been sent out from National Office. Almost daily, requests are being received from nurses, members of parliament, libraries, universities and University Women's Clubs.

## *National Office Staff and Annual Meetings*

Your National Office staff has had the pleasure, this spring, of attending provincial annual meetings in Toronto, Montreal, Regina, Nanaimo and Banff. Our General Secretary unhappily had to forego the pleasure of being present at the Newfoundland meeting. After three attempts, poor weather conditions finally won out and her trip was cancelled. The chance to visit the provinces and meet with members of the CNA is always a welcome one.

## *33 Price Street*

The second provincial nurses' association to build a home of its own held an impressive ceremony on May 11. A special guest, in the person of Miss Daisy Bridges, executive secretary of the International Council of Nurses, officiated at the laying of the cornerstone for the new R.N.A.O. building. Miss Bridges was on this continent to present an address at the American Nurses' Association Biennial Meeting in Chicago.

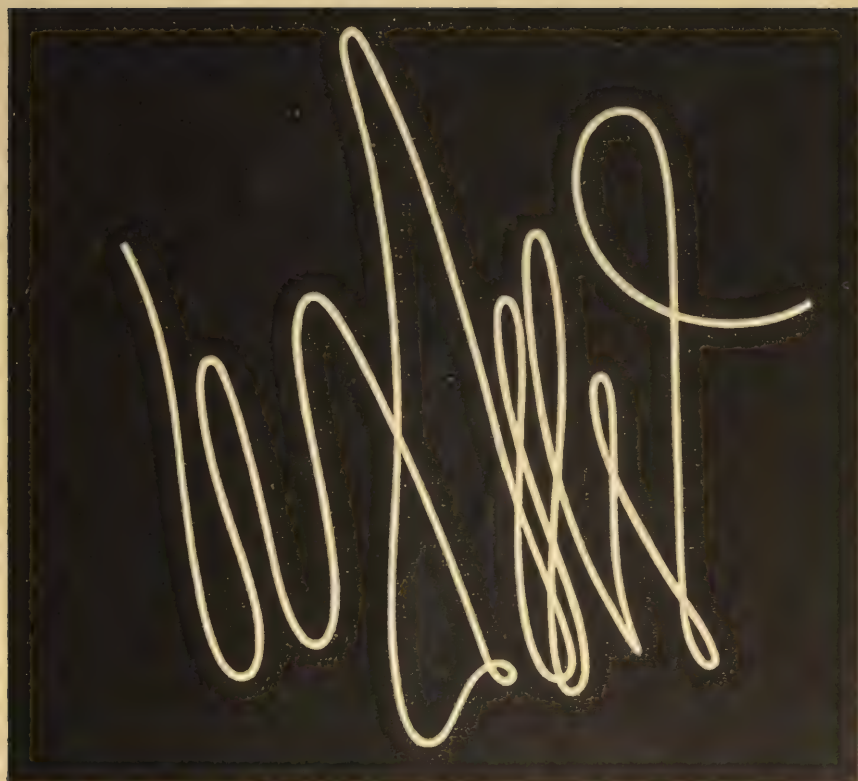
The above street number, as you've guessed, is in Toronto and will be one to make note of when next fall the R.N.A.O. moves to its new quarters.

The first association to build its own home was, as you know, the R.N.A.B.C.

## *Dalhousie Serves the Maritimes*

The school of nursing of Dalhousie University once again brought Mari-





**always an unmistakable pattern...**

..from any angle. Cannot be confused

with bone structure or artifacts  
on the X-ray plate.



*Johnson & Johnson*  
LIMITED MONTREAL

time nurses together for a pooling of experiences and ideas. During the last week in April a refresher course on *Administration and Supervision in Nursing Education* was conducted at Dalhousie University under the able leadership of Mrs. Genevieve K. Bixler, presently director, Nursing Education Project, Southern Regional Education Board, Atlanta, Georgia. Registration was limited and only those who had had at least one year of University study were allowed to attend.

The pattern which the institute followed was that of a presentation on one major area of nursing education in the morning, followed by reading periods and discussion groups in the late morning and afternoon. The last afternoon was devoted to reports from the groups in which conclusions and recommendations were presented. Although each discussion topic was on a different major aspect of nursing education, two main conclusions were made evident. Without both a thoughtful and continuous system of evaluation and dynamic staff education program, curricula no matter how carefully planned and executed, cannot approach their maximum effectiveness.

Mrs. Bixler, a research consultant with many years of orientation to nursing education contributed generously both during the planned sessions with the entire group and by individual consultation. As all who are interested in nursing education know, she is co-author with her husband, Dr. Roy W. Bixler, of the book *Administration for Nursing Education*.

### ***The Registered Nurse in Mental Health***

The Mental Health Division of the Department of National Health and Welfare has released a new pamphlet *Opportunities for Registered Nurses in the Mental Health Field*. One of a series of publications for the recruitment of professional workers for psy-

chiatric hospitals, clinics, and other services, it is aimed at interesting high school students in entering psychiatric nursing following graduation from schools of nursing. It should be useful to vocational guidance officers, instructors in schools of nursing and to registered nurses generally. Requests for copies should be directed to provincial departments of health.

### ***Our Visitors***

We are always happy to have visitors from other countries. Among those who have visited us recently are Miss Nancy Dixon, deputy superintendent of the Queen's Institute of District Nursing, London, England and Miss Dorothy Thomas, assistant matron of the Middlesex Hospital, London, England.

Miss Dixon was naturally very interested in visiting nursing and spent most of her time with the Victorian Order of Nurses visiting the Head Office in Ottawa and several branches in Montreal, Toronto, Hamilton and the Niagara Peninsula. She was particularly interested in the in-service program on rehabilitation which the V.O.N. conducts for its nurses.

Operating theatres, central supply service and nurses' residences were Miss Thomas' main interest and she visited many hospitals in Montreal, Toronto and Ottawa.

These nurses are loud in their praise of the hospitality, interest and cooperation of the many nurses who spend so much time in making the visits of our international visitors so interesting and informative.

National Office is particularly grateful to the nurses who are members of the Canadian Nurses' Association Women's Auxiliary here in Ottawa who volunteer to drive these visiting nurses around the city so that they may see as much as possible of its beauty and the principal places of interest in the short time that they are in the National Capital.

---

The measure of a man is not the number of servants he has, but the number of people he serves.

It is a pleasant thought that when you help a fellow up a steep hill, you get nearer the top yourself.

FOR THE NORMAL INFANT

# LACTOGEN

PRESCRIBE WITH CONFIDENCE

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# *Le Nursing à travers le pays*

## *Progrès en Nursing en 1955*

Il y déjà plusieurs mois, dans ces colonnes, nous vous faisons part que l'A.I.C. avait été invitée à envoyer un article sur le Nursing au Canada pour être publié dans "The Yearbook of Modern Nursing," édité par G. P. Putnam's Sons, New York. Ce livre présente un tableau du nursing actuel et rapporte les principaux événements de l'année dans ce domaine. C'est une compilation d'articles écrits par des représentants des principales organisations en nursing, tant à l'échelon national qu'international.

On y trouve également le texte de conférences, de colloques et de discussions de groupes. Le volume est en vente chez Mc-Ainsh & Co. Ltd., Toronto, au prix de \$4.95 l'unité.

## *Canadiennes outre-mer*

En mai, deux infirmières canadiennes bien connues étaient à Genève où elles assistaient à la 9ième réunion de l'Organisation Mondiale de Santé. Mlle Dorothy Percy, consultante en chef en nursing au Ministère de la Santé Nationale et du Bien-être, conduisit la délégation canadienne. Les infirmières qui ont eu l'avantage d'assister au Congrès de Winnipeg se rappelleront avoir entendu Mlle Percy parler sur: Les infirmières, leur formation et leur rôle dans un programme de santé.

Mlle Alice Wright, secrétaire registraire de l'Association des Infirmières de la Colombie Britannique, était aussi présente à cette réunion; auparavant, elle avait assisté à une réunion du Comité des membres du Conseil International des Infirmières à Copenhague. Mlle Wright visita plusieurs associations d'infirmières en Grande-Bretagne, en Hollande, en Belgique et en Allemagne.

## *Lecteurs variés*

Le mémoire présenté par l'Association des Infirmières Canadiennes à la Commission Royale sur l'avenir économique du Canada est en grande demande. Le Secrétariat National en a expédié 175 exemplaires. Tous les jours nous recevons de nouvelles demandes venant d'infirmières, de députés, de bibliothécaires, d'universités et d'organisations féminines.

## *Le personnel du Secrétariat National et les assemblées annuelles*

Les membres du Secrétariat National ont eu le plaisir, au printemps, d'assister aux assemblées annuelles d'associations provinciales à Toronto, à Montréal, à Régina, à Nanaïmo et à Banff. Notre secrétaire générale a dû renoncer au plaisir d'assister à la réunion des infirmières à Terre-neuve car, après trois essais infructueux, le voyage dut être décommandé à cause de la mauvaise température.

## *Le 33 de la rue Price*

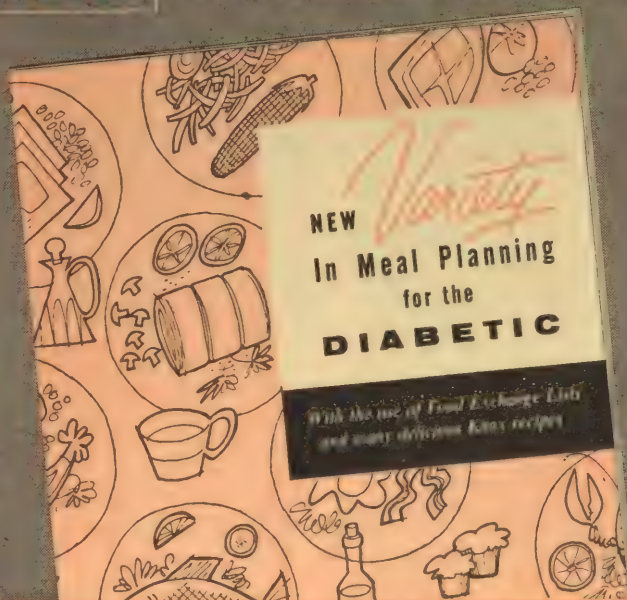
Pour la deuxième fois, une association provinciale vient de décider de se construire une maison. Une cérémonie imposante eut lieu le 11 mai à Toronto alors que Mlle D. Bridges, secrétaire du Conseil International des Infirmières posa la pierre angulaire de l'immeuble qui abritera l'Association des Infirmières de l'Ontario. Mlle Bridges était en Amérique à l'occasion du Congrès Biennal des Infirmières américaines, à Chicago, auquel elle devait adresser la parole. La première association d'infirmières à construire ses propres quartiers fut celle de la Colombie Britannique.

## *L'Université de Dalhousie au service des Provinces Maritimes*

L'Ecole d'infirmières de l'Université de Dalhousie a encore une fois réuni les infirmières des provinces maritimes pour leur permettre de mettre en commun leurs expériences et leurs idées. Durant la dernière semaine d'avril, un cours de perfectionnement sur l'Administration et la Surveillance dans l'Education des Infirmières fut donné à l'Université. L'inscription en était limitée aux infirmières ayant fait une année d'études universitaires. Voici le programme du cours: au début de l'avant-midi, présentation d'un communiqué important sur l'éducation, suivie d'une période de lecture et de discussion en groupe, se prolongeant dans l'après-midi. Au cours de la dernière après-midi, les rapports, les conclusions et les recommandations furent présentés. L'éducation en nursing fut considérée sous divers aspects, mais on en est venu à la conclusion suivante: Le programme d'études, si bien préparé et exécuté

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## Protein Previews



### Newest Knox Brochure Aids Dietary Management of Diabetics



The new Knox booklet "New Variety in Meal Planning" has been prepared to help you enlist the patient's enthusiasm for dietary measures and to help maintain this enthusiasm. It explains the importance of diet to the diabetic, shows him how to use the newest dietary advance—Food Exchange Lists<sup>1</sup>—and then describes how to provide tasty variety with 14 pages of tested, diabetic recipes.

"New Variety in Meal Planning" makes no attempt to prescribe a system of treatment. It shows how the recipes described may be used to good advantage in practically any system of diabetic management. If you would like a supply

for your own use, fill in the coupon below.

1. The Food Exchange Lists referred to are based on material in "Meal Planning with Exchange Lists" prepared by Committees of American Diabetes Association, Inc., and The American Dietetic Association in cooperation with the Chronic Disease Program, Public Health Service, Department of Health, Education and Welfare.

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YOUR NAME AND ADDRESS

soit-il, ne peut donner son maximum d'efficacité qu'à la condition d'être continuellement évalué et appuyé par un programme dynamique d'éducation du personnel. Mme Bixler, consultante en orientation dans le domaine de l'éducation en nursing, a contribué généreusement au succès du cours. Elle est l'auteur, conjointement avec son mari le Dr. Roy W. Bixler, du livre intitulé: "Administration for Nursing Education."

### *L'infirmière et la santé mentale*

Le Service de l'Information du Ministère de la Santé Nationale et du Bien-être social vient de publier un feuillet intitulé: "Avantages offerts aux infirmières en hygiène mentale." Ce feuillet fait partie d'une série de publications ayant pour but le recrutement du personnel professionnel dans les hôpitaux psychiatriques, cliniques, etc. Il s'adresse aux étudiantes des écoles supérieures afin de les intéresser au nursing en psychiatrie advenant le cas où elles se dirigeraient vers la profession d'infirmières, une fois leurs études terminées.

### *Nos visiteuses*

Il nous fait toujours plaisir de recevoir des visiteurs de pays étrangers. Récemment,

nous avons eu la visite de Mlle N. Dixon, directrice adjointe du Queen's Institute of District Nursing, de Londres, Angleterre, et Mlle D. Thomas, assistante de la directrice du Middlesex Hospital, de Londres également. Mlle Dixon était tout particulièrement intéressée à visiter les organisations d'infirmières visiteuses. Elle a visité les quartiers généraux du V.O.N. à Ottawa et le service de la même organisation à Montréal, Toronto, Hamilton et Niagara. Le service hospitalier à domicile des malades, fait par les infirmières du V.O.N. et leur réadaptation ont été l'objet d'une étude particulière.

Mlle Thomas a visité plusieurs hôpitaux à Montréal, Toronto et Ottawa, dans le but de voir les salles d'opération, le service central et les résidences des infirmières.

Ces visiteuses ont fait beaucoup d'éloges de la généreuse hospitalité qu'elles ont reçue durant leur séjour au pays ainsi que de l'intérêt que leur ont manifesté un grand nombre d'infirmières.

Le Secrétariat National remercie particulièrement les infirmières membres de la section des dames auxiliaires de l'Association des Infirmières Canadiennes, à Ottawa, qui ont bien voulu conduire nos visiteuses à travers la ville et dans les environs afin de leur faire admirer les beautés de notre capitale.

## **In the Good Old Days**

*(The Canadian Nurse — JULY, 1916)*

A survey of 403 practical nurses working in Detroit revealed that a great many were rejected probationers from hospital schools. They objected to the rule that they must not wear white uniforms as they wished to be called "trained nurses." They are by all odds the most difficult type to deal with.

\* \* \*

The highest medical authorities have finally agreed that cancer does not result from a germ but from some unknown form of body poison which spreads through unhealthy tissue suited to its propagation and ultimately destroys that tissue.

\* \* \*

Canadian nurses in the C.A.M.C., with their lieutenant's rank, mixed things up a bit at first as military discipline as usually applied to officers of that rank was a misfit. English nurses do not have as much freedom of action as do the Canadians. They

would never be allowed the liberty of dancing or of having afternoon tea with the male officers at the Sisters' Mess.

\* \* \*

Great pleasure was expressed that the new nurses' residence of the Vancouver General Hospital was available for the reception following this year's graduation. It is a magnificent building.

\* \* \*

Laws are needed to regulate the practice of nursing. They reflect the character and intelligence of the people. The time is ripe for legislation to protect the fully qualified graduate nurses.

\* \* \*

Some of our nurses have been taking bicycles over from England for use behind the lines in France. French firms are too busy making munitions to manufacture bicycles.



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Get more pad for your money with the thicker, softer 12-inch No. 656 Kotex. An improved process lays cellulocotton fibres into a fuller, fluffier filler. As a result, fewer pads are needed and less time spent in changing pads.

**NEW MATERNITY BELT.** For most efficient operation with the No. 656 Maternity Pad, use the new Kotex Maternity Belt. Forget old-fashioned T-binders. New belt fits around waist and snaps on—no pins!

**BIG SAVINGS!** Save dressing costs and hours of nurse time. See your Curity representative for details today!

## Extra Features of 12-inch No. 656 Kotex Pad

- Rounder, softer edges for greater comfort to patients.
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Note the Difference

In Thickness

The No. 656

Kotex Pad

An Ordinary  
Maternity Pad

# Book Reviews

**Nursing Practice and the Law**, by Milton J. Lesnik and Bernice E. Anderson, R.N., Ed.D. 384 pages. J. B. Lippincott Company, 2083 Guy Street, Montreal, P.Q. 2nd Ed. 1955. Price \$6.00.

*Reviewed by Miss Lola Wilson, Secretary-Registrar, S.R.N.A., Regina.*

Although this book is written and illustrated from various cases involving nurses in the United States, it contains a wealth of material that could be read with benefit by all nurses in Canada. As one reads it, one must continually bear in mind that what is written in the laws of the United States at the federal level or at the state level, may not necessarily apply in Canada or in specific provinces in Canada.

There are three chapters in this book that are of particular interest. Chapter IV deals with "Legal Control, Nursing Practice Acts: Analysis and Evaluation." The authors state in the very beginning of this chapter that "Legal control over a profession requiring skill and education for its adequate performance is based upon the police power of the state to secure the people from incapable, deceptive and fraudulent practitioners." The chapter deals with current legislation in the United States and the nursing Acts relative to the various states in the United States with special reference to the appendices, spelling the early Acts out in full. The entire chapter contains a challenge for every registered nurse to work toward more effective legislation for nurses. The following statement in this chapter, "The contribution of an effective administrative agency to secure the public will be related directly to the extent of knowledge, wisdom and experience of its members" is one that we, the registered nurses of Canada, cannot ignore.

The chapter relative to "Contracts for Nursing Services" bears careful review. The continual mention of the implied contract throughout this chapter brings very acute awareness of the responsibility of nurses to fully acquaint themselves with the implications of agreements they may make in relation to service.

The outstanding chapter in the entire book, in our opinion, is the one dealing with "Legal Aspects of Negligence and Malpractice." This chapter is not only an attempt on the part of the writers to impart information relative to negligence and mal-

practice, but also to stimulate nurses to accept the fact that if we are to be classified as a professional group, we must assume our own professional responsibilities. Such statements as "The security of a profession is identity." "The majority of malpractice actions involving nurses relate to injuries sustained as the result of the failure to do something," etc., make one ponder. Nursing must assume its professional responsibilities but, in assuming them as a group, we must recognize that it is the *individual* who is most likely to be called upon to answer for her actions in a court of law. We must be certain that the individual is fully aware of the legal implications of professional practice and that she understands that she is responsible for her own actions. We, as an organized profession, are responsible to society and to professional nurses in making a real effort to more carefully define what professional nursing practice is.

Time and again it is emphasized that we must define the functions of professional nursing. Research is necessary so that this can be done. Although we have entered into the realm of an accepted profession, the authors state that nurses still entertain the fallacy that they are absolved automatically from liability by performing and executing an order of a licensed physician. The authors point out that no person may absolve another of liability and that no physician may order a nurse to perform an act and assure her that he will assume full responsibility. They state "The nurse who acts pursuant to such an understanding, without an appreciation of the cause and effect of the order she is to execute, renders herself and the patient a disservice. The law is clear that a nurse is required to understand the procedure or technique she is directed to apply." The entire chapter points to the need for a clearer definition of professional nursing functions and as an immediate result, therefore, a clearer definition of the role and function of the practical nurse (in Canada, the generally accepted term is "nursing assistant") group.

This book is well written and very easily understood. Regardless of the fact that it may refer on the whole to nursing practice in the United States, the basic concepts and principles dealt with do not differ from Canada. In our opinion this is a book to be read with benefit by every nurse.

# News Notes

## ALBERTA

### DISTRICT 3

#### BANFF

A busy round of activities has been planned by this chapter. The Baby Clinic, held monthly, reports a good attendance. A film showing under the auspices of the Cancer Society was held in April. Mrs. Lister, at a recent meeting, gave an excellent report of the Cancer Workshop, which she had attended as group representative. The Bursary Committee has completed the wording of and the regulations governing the award of the chapter bursary to a girl choosing nursing as a career. The presentation of the award is to take place in June. Tentative plans are in progress to hold a public speaking course in the fall.

To allow members to attend the conference held at the School of Fine Arts, the chapter voted the funds necessary to pay the registration fee to the Alcoholism Foundation. It afforded an excellent opportunity for those interested in acquainting themselves with the problems created by alcoholism to increase their knowledge.

To offset the hazards produced by tourist travel and the usual large influx of visitors, members have arranged to assist in the event of large scale accidents or other emergencies and have been mobilized into teams of five with one nurse responsible for keeping the other members of her group informed.

#### CALGARY

Members received some very good advice on how to invest their money at a recent meeting. Mr. J. V. Sorsliel of Nesbitt Thomson Investment Co. was the guest speaker at the supper meeting.

#### VULCAN

The past year has been an active one for this chapter. A series of civil defence lectures, demonstrations and films under the direction of Mr. Wm. Shields formed an important part of the educational program. Home nursing classes are being continued. The Shut-In Project which took the form of provision of a TV set for a patient at home with a long-term illness is proving to be a source of great pleasure and satisfaction. The Blood Donor Clinic has received considerable assistance.

### DISTRICT 4

#### MEDICINE HAT

Several delegates represented the chapter at the annual provincial convention in Banff. A rummage sale was held in February

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NURSES**

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your hands frequently**

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- Completely Absorbed and Utilized
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Box 129, Montreal.

• Please send me FREE, Physicians Handy Pocket Size  
Formula Guide and Prescription Pad ☐

• Children's Grow Charts ☐ Crown Brand Samples ☐

•

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ADDRESS.....

.....

with considerable success. Mrs. Currie and Mrs. Skinner discussed the Council of Social Service in the city as guest speakers at one recent meeting while Dr. Van Belkum was a welcome guest and speaker at another.

### RED DEER

Executive officers for the current year are: Mrs. Pollock, pres.; Mrs. McKeown, vice-pres.; Miss Yuill, treas.; Mrs. Flegal, rec. sec.; Mrs. Forbes, corr. sec. Guest speakers during the early part of this year have included Dr. R. Chadwick who pictured for his audience some of his experiences while living and working in China, and Mr. Sinclair, president of the Twilight Homes Foundation.

### DISTRICT 7

#### GRANDE PRAIRIE

Members elected to the executive for the current year include: Mrs. K. Murray, pres.; Mrs. M. Martin, vice-pres.; Mrs. B. Butchart, sec.; Mrs. M. Orr, treas. This chapter reported a very active year during 1955. Programs were based around civil defence developments, private duty nursing and other timely topics.

### STONY PLAIN

The following members were elected to office for the current year: B. Cogland, pres.; Mrs. S. Mills, vice-pres.; Mrs. J. Wood, sec.-treas. The programs presented during the early part of this year have been most interesting and have included the story of antibiotics as portrayed in the film "The Earth Shall Give Back Life"; a description of the care of the patient with a colostomy and a summary of information relating to new drugs recently introduced into general use. A visit to the Cerebral Palsy Centre was very much appreciated by those attending.

A donation was sent to the Unitarian Service from this chapter to aid Greek Red Cross nurses. Members assisted with the local Red Cross canvass. The guest speaker, Mr. Howie, gave a most interesting and enlightening address on the legal aspects of nursing as related to "The Legal Rights of Married Women," at one of the chapter meetings.

A visit to the Cerebral Palsy Clinic, Edmonton, highlighted a spring meeting of this chapter. The group visited each department of the Clinic and the various staff members discussed their work informally and answered questions. Mrs. H. Meicklejohn was the official delegate to the annual meeting of the A.A.R.N.

## WAINWRIGHT

Members elected to the executive for the current year were: Mrs. R. Wallace, pres.; Mrs. M. Middlemass, vice-pres.; Mrs. I. Harick, sec.-treas. A midwifery kit was sent to "CARE" as a chapter project. During the past year members have enjoyed a varied and interesting program of activities ranging from cerebral palsy, cancer and cancer research and infectious hepatitis to guidance clinics. The Blood Donor Clinic and Cancer Drive received assistance from this chapter.

## WESTLOCK

Members participated in the civil defence program held at Immaculata Hospital. The chapter scholarship was awarded to J. Mountain, who recently entered a school of nursing. A fashion show was sponsored as a fund-raising project.

## BRITISH COLUMBIA

### CRANBROOK

Miss J. Reid, physiotherapist for the local branch of the Canadian Arthritis and Rheumatism Society, was the guest speaker at a recent chapter meeting. She outlined the treatment available and conducted a tour of her department, demonstrating and explaining the many mechanical and electrical aids. Mrs. S. L. Hewer of the Canadian Red Cross Society, Vancouver branch, also visited the meeting briefly to discuss the steps in establishment of a loan cupboard.

A scrapbook of press clippings recording the activities of the chapter and district has been initiated. At a recent meeting, members listened with interest as two representatives of Alcoholics Anonymous discussed the problems related to this condition. Mrs. C. Kram was the delegate to the annual R.N.A.B.C. meeting.

### LADYSMITH

D. Hallan attended the annual provincial meeting held earlier this year as the official chapter delegate. A donation of money was forwarded to assist in the purchase of uniforms for needy Greek nurses.

At the nurses' annual tea which was held in mid-May, a special party was arranged for the pre-school children who attended with their mothers while the latter enjoyed a display showing the prevention and treatment of poliomyelitis. Mrs. J. Field, a councillor for the Vancouver Island District, was guest speaker at one of the chapter meetings.

### PRINCE GEORGE

A panel of speakers, Mmes D. Parks, L. Houde and Miss E. Gildner discussed the highlights of the Public Health institute held earlier. Topics included the latest developments in the care of the handicapped child, the control of staphylococcal infections, tuberculosis nursing and rehabilitation, the effects



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Pain upsets a woman's poise and appearance, whatever her job. Her work becomes much more difficult, adding tension that is unnecessary today. That's why relief from pain is so important, especially to nurses . . . not just at specially difficult times, but *every* time pain occurs.

Veganin tablets are recommended by physicians and dentists . . . especially for "stronger" relief . . . since Veganin contains approximately 8 grains of anti-pain medication. Available in handy tubes of 10's and 20's for pocket or purse.



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## So much more than merely a mouth rinse

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LD-35

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of stress in modern society. Special guests at this meeting were public health students from Saskatchewan University presently doing field work in the area.

### QUESNEL

Chapter members have donated books for the library of the new G. R. Baker Memorial Hospital. A cheque was forwarded in response to the plea for uniforms for Greek Red Cross nurses.

A bake sale in May helped to provide the funds necessary for a bursary to be given to one member of the Future Nurses' Club who enters nursing. Plans are progressing for the annual meeting of the district in September.

### SOUTH FRASER CHAPTER

O. Clancy, president, was the representative to the annual R.N.A.B.C. convention this spring while J. Keays attended the Biennial Convention in Winnipeg. A donation was allocated to the Greek Red Cross to assist with the work of this group.

### TRAIL

Plans have been made to give Salk polio vaccine to preschool children and those in grades three to nine. Booster doses will also

be available for those who were inoculated last year. Mrs. Morris and Mrs. Miller have been appointed to the committee responsible for administering the Alice Chesser Memorial Fund.

### VANCOUVER

#### *St. Paul's Hospital*

Mrs. G. Collishaw represented the alumnae association at the annual R.N.A.B.C. meeting in Nanaimo earlier this year. The class of August 1947 held a reunion at the home of Mrs. (Korte) Russell with 18 members present. A coffee party and sale of home cooking was sponsored by the Dunbar-Fairview group. Proceeds were donated to the Bursary and Benevolent Funds. Dr. E. M. Stevenson was a guest speaker at one of the regular meetings and chose the "Nurse's Orientation into Psychosomatic Medicine" as his topic.

### VANCOUVER ISLAND

#### COMOX

The history of fluoridation of water supplies, a description of the comparative studies carried out at Brantford, Ont. and a comment on the acceptance of this practice in



Canada and the U.S. formed the theme of a very timely address by Dr. G. F. Gemeroy at a recent chapter meeting.

At a subsequent meeting Sr. M. Louise, a past vice-president of the Ontario Hospital Association, chose as her subject "The Nurse's Ideal — The Ideal Nurse" and remarked on the changes in the spirit of nursing effected by changes in nursing education and administration. D. Henderson and M. Cutler attended the annual provincial meeting as official delegates. A donation was made to assist in building up the fund to help Greek Red Cross nurses.

## MANITOBA

### BRANDON

The annual tea sponsored by the Association of Graduate Nurses was held earlier this year in the residence of the General Hospital. Homecooking and candy tables were featured. The event proved most successful both socially and financially. Proceeds will be used for scholarships for graduate nurses wishing to pursue further study in nursing education.

### General Hospital

Seven student nurses received their caps and were welcomed into the school of nursing, late in April. H. Conroy, M. Edwards, S. Fleming, J. MacDonald, P. McCunn, S. Stepler, and S. Watson repeated the Florence Nightingale Pledge led by their director of nursing, Miss M. E. Jackson.

## NEW BRUNSWICK

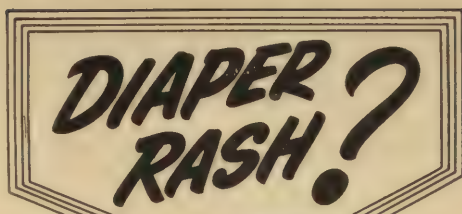
### MONCTON

H. Hayes, president of the chapter, was appointed to attend the biennial convention. At a recent meeting, Mrs. C. Colwell reported from the Nursing Education committee that Miss Gionet, Hotel Dieu, is taking postgraduate study in Montreal while D. Steeves, R. MacKenzie and C. Donovan attended a three-day institute at Halifax on "Aspects of Rehabilitation." R. MacKenzie has completed a ten-weeks course at Dalhousie University in Mental Hygiene in Public Health. Rededication services for nurses were held early in May. Preparations for publishing a cook book as a chapter project are well advanced. It has also been decided that a prize for obtaining the highest standing in the principles and practice of nursing will be donated to a nurse from each of the city hospitals.

S. MacLeod, supervisor of obstetrics at Moncton Hospital, and L. Smith, field supervisor for the Department of Health, were guest speakers at one of the spring meetings.

### SAINT JOHN

The private duty section of the local chapter held a supper meeting in the Royal Hotel early this spring with an attendance of 26. M. Downing was the guest speaker and gave a most interesting description of her trip to Guatemala.



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## General Hospital

The proceeds of a successful pantry sale are being used by the alumnae association to help furnish a room in the new residence.

P. Radcliff and J. Rawding have enrolled for postgraduate study in the Montreal Neurological Institute. M. K. O'Brien has undertaken a three year course of study in Nursing Science at Boston University. D. Pickett has joined the staff as assistant supervisor on Fourth floor. Miss Pickett, a recent graduate, obtained second place standing in the provincial examinations for registration. Other appointments to the staff have included M. McGarrity and B. Byron, 1st floor; C. Fife and E. Clark, 3rd floor; P. Tolan, 2nd Floor; A. M. McLaughlin, nursery; R. Cashal, O.R.

To assist the alumnae association with its project of publishing the history of the school of nursing, the Juniorettes presented the "Pulse Takers Jamboree" — an evening of plays, monologues, singing and dancing which was thoroughly enjoyed by all who attended.

## NOVA SCOTIA

### SYDNEY

#### City of Sydney Hospital

A review of the activities of this alumnae association demonstrates clearly the value of such an organization and the devotion and industry of its members. The main objective is service — to the hospital, to the student nurses, to alumnae members.

A private room in the new building has been furnished by the members of the association. A television set and other electrical appliances have been donated to the student residence. The living room and kitchen of the same building were renovated as another alumnae project. Funds have been donated at various times for student parties and dances, and Community Concert tickets supplied. A loan fund has been made available to any graduate of the hospital wishing to pursue further studies. Each year a banquet is given in honor of the graduating class and two prizes are donated to the two members of the class who perform outstanding work in dietetics. Sick graduates or students receive special attention in the form of greeting cards, flowers and visits.

Funds for these activities are raised through sales of homecooking, knitted goods, other articles of sewing and dolls. Parcelpost packages and bridge parties are an additional source of revenue.

## ONTARIO

### DISTRICT 1

### LONDON

#### Victoria Hospital

A gift of \$50,000 to be used in the foundation of a memorial to the late Miss Ione Holdsworth was recently received by the



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hospital. The contribution was a bequest in the will of the late Mr. Byron Lee Thurber, a Canadian who settled in South Africa. Miss Holdsworth, who had helped to care for Mr. Thurber during a sudden illness while he was visiting Canada, died in an automobile accident in 1941.

The alumnae association this year celebrates its 50th anniversary. It has been planned to postpone any large-scale activities in recognition of the occasion until 1958 when the school of nursing will celebrate its 75th anniversary.

Miss O. Branion retired early in 1955 after 29 years of devoted service to her hospital. She has the enviable record of never having lost one day's work through illness during that time. Miss Branion was the guest of honor at a surprise party given by over 200 nurses and associates who had served under her guidance. The medical staff of the hospital arranged a luncheon in her honor. On each occasion she was the recipient of beautiful gifts. Members of the Hospital Trust, the staff of Fifth Floor N, and the nursing staff also expressed their appreciation through presentation of gifts.

Miss V. Vance also retired after 34 years of service as a public health nurse. A reception was held at the service center of the hospital and a presentation was made by Dr. C. A. Harris.

D. C. Hall has been appointed to the faculty of nursing education at the University of Bangkok, Thailand. G. Erskine has accepted the position of assistant director of nursing service in her home school. E. McIlveen is pioneering in the teaching of public health to students in Teachers' College, Toronto. M. Drummond is attending the University of Toronto where she is enrolled in the advanced course in administration and supervision in public health nursing. N. Hicks is doing school nursing in Ottawa. G. Appleyard is on the staff of the Obstetric Hospital, Hamilton. Mrs. H. (English) Mason has returned to St. Petersburg, Fla. after completing special study at Columbia University. H. Sentesy is an air-hostess with T.C.A. and is presently stationed in Montreal. N. Shepanski has joined the staff of Ann Arbor University Hospital. G. Earnest and B. Jinx are on the staff of the King Edward VII Memorial Hospital, Bermuda.

The alumnae association celebrated its 50th anniversary in May with members of the 1956 graduating class present as guests of honor. The highlight of the evening was a pageant entitled "Remember When" presented by members of the alumnae under the direction of Mrs. G. McCulloch. Several charter members were also present as guests of honor: Mrs. M. Patterson; Miss L. Uren,





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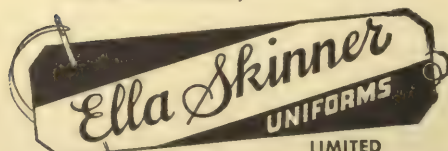


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first secretary-treasurer; Mrs. J. Atcheson; Mrs. E. M. Kidd; Mrs. G. Wilson, 1906 alumnae president. Ceramic figurines depicting uniforms worn by nurses over the last 70 years decorated the head table at the anniversary dinner. They were prepared by Mrs. J. Fisher. Banquet tables were centred with yellow and purple flowers carrying out the anniversary theme and the school colors. The anniversary cake was cut by Mrs. Wilson, and a cake symbolic of the three years of professional training was cut by Miss L. Blair, a member of this year's graduating class. Both cakes were baked by Mrs. A. Blair in honor of her daughter's graduation.

This was a most successful event and members are already anticipating the functions to come when the hospital celebrates its 75th birthday in 1958.

Miss Helen G. McArthur gave the address to the graduating class at their exercises. She stressed the unique opportunity offered nurses through the joy of accomplishment in the many fields of activity open to them. The impact of nursing on the international scene as a stabilizing force was also emphasized. Scholarships for postgraduate study, donated by the auxiliary, were awarded to Barbara G. Brown and Margaret A. Cochrane.

## DISTRICT 2

### WOODSTOCK

#### General Hospital

P. Smith, hospital administrator, addressed the alumnae association at a recent meeting, on "The Use of Drugs." Members of the graduating class of this year were guests of honor. Civil defence lectures are being given weekly for alumnae members and assistance with a tuberculosis survey has been undertaken as a major project. Provision of pyjamas for patients in the Children's Wing was another recent undertaking.

## DISTRICT 5

### TORONTO

The annual district meeting was held early in the year with election of the following officers: Ruth M. Watson, pres.; Mrs. R. Couse, J. Ives, vice-pres.; F. Howard, chairman, Chapter 1; Mrs. V. McPherson, chairman, Chapter 2. A highlight of the various reports was the fact that 63 student nurses have benefited by the Degree Course Bursary Fund.

#### Women's College Hospital

The Board of Governors has again offered a scholarship to a member of the graduating class who wishes to pursue postgraduate study in teaching or administration in schools of nursing. Although preference is given to an application from a member of the graduating group, any alumnae member in good standing may apply as well.

W. Adair is presently on the staff of the Glendale Community Hospital, California.

## TORONTO

### General Hospital

B. McCabe recently assumed the position of O.R. supervisor, Victoria Hospital, London. I. Moore, who has been matron of nursing at a leper colony near Hong Kong for several years, has returned to Canada on furlough. M. McMurtry is nursing in Hawaii. A. Coakwell has joined the Occupational Therapy Society of the city as a social service worker. L. Evans is studying in New York. D. Gildner, A. Maksinik and R. Gaw are working with T.C.A. M. Stinson is on the staff of the Outpatient department, Women's College Hospital. C. Campbell has joined the staff of the Eye Surgery Hospital. V. Day returned to her home school for a short time to take a refresher course.

G. McBroom has been appointed supervisor of the Private Patients' Pavilion with I. Ferguson as her assistant. E. Hawke accepted a position as head nurse while A. Quinn and R. Rayfield are assistant head nurses. P. Osborne is doing private duty and A. (Sweetman) Hillmer is working in the Emergency Dept. S. (Robson) Veale has joined the staff of Ajax General Hospital. B. Chapman is a health nurse with the Canadian Kodak Co. M. (Kennedy) Briar is doing public health work in Vancouver. B. Rowland has joined the Charlottetown Public Health Dept. R. (Irvine) Graham is on the staff of Scarborough Township Board of Health and J. (Anderson) Williamson is with the East York Leaside H.U.

## DISTRICT 8

## OTTAWA

### Civic Hospital

Plans are underway for a bazaar and tea to be held in the nurses' residence in November. Gift and knitting tables are to be featured as well as a sale of aprons made by the members. Donations for a post office sale are wanted — articles wrapped for mailing which will be sold unopened.

D. Grieves is on the staff of the General Hospital, Saint John, N.B. V. Holinshead has moved to the Outpatient Department of Toronto General Hospital. H. (Stephens) McLennan is presently taking a course in Intravenous Therapy and Dressing Technique in Vancouver. F. Alderwood is on the staff of Westminster Hospital, London. R. Miskelly is enrolled in the teaching and supervision course of the University of Toronto. D. McPhee is majoring in public health, Ottawa University. H. Kennedy is currently a member of Stormont, Dundas and Glengarry Health Unit, Cornwall. M. Langtry is on the staff of Peterborough Board of Health. Lieut. N/S J. Doerr has been posted to the staff of Kingston Military Hospital following completion of her public

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health course, McGill University. V. MacRae is presently on the staff of the Royal Alexandra Hospital, Edmonton, while K. Pincombe is doing tuberculosis nursing at the Halifax Tuberculosis Hospital. Lieut. N/S M. B. Shaw has been posted to Whitehorse Military Hospital, Yukon Territory. S. Anderson has joined the staff of North Bay Civic Hospital. B. (Aikenhead) Carriere is clinical instructor of Victoria Hospital, Renfrew. G. Purpee has returned to the staff of her home hospital and E. Hodgins is engaged in private nursing in the city. L. Moke is with the Ottawa Public School Health Staff. I. Simister is nurse-in-charge with the V.O.N., Calgary. T. Pritchard has joined the staff of Temiskaming Health Unit. M. (Taylor) Berry is working on the Children's ward of North Lonsdale Hospital, Lancs., England. E. MacDougal is with the Galt Branch of the V.O.N. B. Loucks is nursing in the E. Crowe Memorial Hospital, Eriksdale, Man.

### *Lady Stanley Institute*

The annual dinner of the alumnae association was held early in March. Guests were welcomed by Mrs. G. O. Skuce, president. Mrs. C. Port displayed many interesting items to be used for the Book of Remembrance. Following the business session, members in attendance listened to a reading by Miss M. Stewart, director of nurses of the Royal Ottawa Sanatorium in which she told of the love story of Florence Nightingale and the Reverend John Smithurst.

### PEMBROKE

This chapter has been enlarged to include the nurses of Deep River, Renfrew and Arnprior with a membership of 158 active nurses and 39 associates. Proceeds of a telephone bridge and raffle were used to help pay the expenses of a delegate to the Biennial Convention.

### QUEBEC

#### DISTRICT 3

### SHERBROOKE

The following members have been elected to executive positions in the English Chapter: C. Aitkenhead, chairman; O. Harvey, vice-chairman; A. Bertram, sec.; Mrs. D. Hudson, treas.; Committees: Educational, G. Norris; Private Nursing, Mrs. H. Morrison; Industrial Nursing, D. Symons; Public Health, Mrs. M. Watson; Institutional Nursing, L. Henshaw. Rep. to *The Canadian Nurse*, S. Carson.

### *Sherbrooke Hospital*

As guest speaker at one of the staff meetings, Dr. R. Bayne discussed geriatric care from the point of view of nursing care involved, the necessity for adequate rehabilitation and the place of occupational therapy





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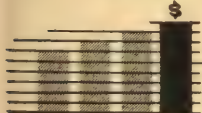
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## DISTRICT 11

### MONTREAL

#### General Hospital

Evelyn B. Moulton of the staff of Queen's University School of Nursing was a recent visitor. Margaret Keddie of the Royal Infirmary, Aberdeen, Scotland spent some time in observation in the hospital and school of nursing. She is sister-tutor in charge of the preliminary training school for Aberdeen general hospitals and is studying the methods of nursing education employed on this continent.

In mid-April a bridge party, under the sponsorship of the alumnae association, was held in Livingston Hall and proved most enjoyable and successful. Funds were in aid of the E. Frances Upton Memorial Fund. Miss Herman, the president, and her committee under the convenship of Miss Jensen deserved the credit for the success of the undertaking.

Plans for the combined reunion of past members of the resident medical staff and their wives and members of the alumnae association are progressing. A program of tours, teas, a fashion show, banquet and class reunions has been worked out and all graduates are most cordially invited to plan to attend.

The first issue of the alumnae news letter was distributed to members in April.

#### Royal Victoria Hospital

The graduating class of 1956 was honored at a dinner given by the alumnae association in the Ritz Carlton Hotel early in May. The toast to the guests of honor was proposed by Miss Mima Russell, class of 1896 and responded to by F. MacDowell. The guest speaker of the evening was Miss Edith MacDowell, Dean of the Faculty of Nursing, University of Western Ontario. The classes of 1931 and 1946 took this opportunity to enjoy a reunion of their members. Prize winners in the graduating class included S. Messenger, Mabel F. Hersey prize; J. Easson, Alexina Dussault prize; W. Cairns, Nellie Goodhue prize.

A large number of members and friends attended a tea during graduation week at which a portrait of the late Miss Fanny Munroe was unveiled. The portrait was presented to the hospital by Miss G. Purcell on behalf of the members of the alumnae association. It was unveiled by Mrs. Marjorie (Dobie) Munroe and accepted on behalf of the hospital by Mr. G. Blair Gordon, president of the Board of Governors. Painted by Mr. O. deLall, the portrait is an excellent likeness of Miss Munroe in her nurse's uniform.

The annual meeting of the alumnae association was held in the nurses' residence with election of a new slate of officers. Members of the executive include: Mrs. E. Butler, pres.; Miss H. Lamont, Miss D. Goodill, vice-pres.; A. Hathaway, rec. sec.

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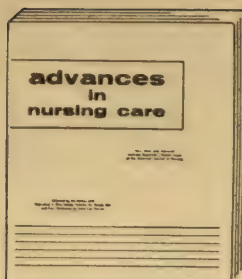
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- (5) Zone Supervisor of Nursing, Box 292, North Bay, Ontario.
- (6) Zone Supervisor of Nursing, P.O. Box 3427, St. Roch Branch, Quebec, Que.
- (7) Moose Factory Indian Hospital, Moose Factory, Ontario.

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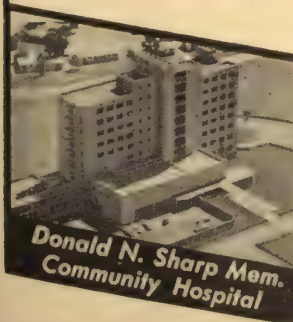
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DUTIES TO COMMENCE JULY 1, 1956.

Degree in nursing education with  
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New Educational Department  
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Expected registration 200 students.

APPLY: DIRECTOR OF NURSING,  
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**PUBLIC HEALTH NURSES**

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Applications will be considered from Registered Nurses without Public Health training but with University entrance qualifications.

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*and*

**NURSING ARTS  
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**SCHOOL OF NURSING**

(In operation since 1908)

Registration: 100 students

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Degree in nursing education with  
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Salary open

**APPLY: ALEX E. NORTON, Superintendent  
NEW ROCHELLE HOSPITAL  
NEW ROCHELLE, NEW YORK**

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**Director of Nursing for fully accredited 185-bed hospital on or before Sept. 1, 1956.** Must have administrative training & experience & be capable of assuming direction of all phases of nursing & nursing technique. Good personnel policies. Attractive apt. available in nurses' residence. Good salary for fully qualified person. Please state qualifications & experience to Supt., County General Hospital, Welland, Ont.

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**Director of Nursing Service (Immediately) for 276-bed General Hospital.** Postgraduate course in administration favored, experience preferred. Apply Administrator, St. Paul's Hospital, Saskatoon, Saskatchewan.

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**Asst. Director of Nursing for 450-bed hospital with school of nursing.** Experienced, preferably with University Certificate of postgraduate training. Salary according to experience. 40-hr. wk. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

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**Night Supervisor, Head Nurse, Assistant Head Nurse & General Duty Nurses for 156-bed Pediatric Hospital.** Rotating shifts for staff nurses. Student nurse affiliation program in Orthopedic-Pediatric nursing. Apply Director of Nursing, Alberta Red Cross Crippled Children's Hospital, Calgary, Alta.

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**Superintendent of Nurses (1).** Salary: \$275 per mo. **Graduate Nurses (2).** Salary: \$225 per mo. less \$40 per mo. room, board & laundry. 28-bed hospital, pleasant surroundings, 5 mi. from U.S. border. 40-hr. wk., 4 wk. vacation after 1 yr. service. 1½ days sick leave per mo., yearly accumulative. Nice nurses' residence. Apply The Grands Forks Community Hospital, Grand Forks, B.C.

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**Supervisor (Experienced)** to act as Assistant Superintendent in a general supervisory position in active 50-bed hospital, near Toronto. Apply giving full information as to qualifications, experience & references to Supt., General Hospital, Cobourg, Ont.

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**Superintendent of Nurses for modern 42-bed hospital on or before Aug. 1, 1956.** Qualified to assume direction of nursing staff & have experience in all phases of nursing & nursing technique. Please apply stating qualifications, experience & salary requirements to Administrator, New Liskeard & District Hospital, Box 340, New Liskeard, Ont.

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**Supervisor (4 P.M. to 12 P.M.) for new, small General Hospital. General Duty Registered Nurses.** Good personnel policies. Full maintenance in attractive, new residence. Apply Supt., Niagara Hospital, Niagara-on-the-Lake, Ontario.

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**Operating Room Supervisor, Night Supervisor & Staff Nurses.** Good salary & personnel policies. Living accommodations available. Apply Director of Nurses, General Hospital, Parry Sound, Ontario.

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**Supervisor (qualified.)** Good salary. Extra allowance for experience if French speaking. 5-day wk., 4-wk. vacation, 18 days sick leave cumulative annually. Car is provided. Half cost of uniform is allowed & half of Blue Cross. Workmen's Compensation. Good working conditions. Apply Sec.-Treas., Porcupine Health Unit, 164 Algonquin Blvd. E., Timmins, Ont.

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**Superintendent of Nurses for 22-bed hospital.** Good salary offer. Increments every 6 mo. for 3 yrs. 1 mo. vacation after 1 yr. employment. Statutory holidays. 15 days sick leave accumulative to 90 days. Well equipped hospital & modern nurses' residence. On main highway. Good transportation facilities. Write or phone Supt. of Nurses or Sec.-Manager, Union Hospital, Hafford, Sask.

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**Matron & General Duty Nurse for 8-bed hospital.** Salaries: \$265 & \$235 gross with 6, \$5.00 increases every 6 mo. \$25 maintenance in separate nurses' residence. 8-hr. shifts. 1 mo. vacation. Sick leave. Apply Sec. Treas., Kyle-White Bear Union Hospital, Kyle, Sask.

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**Matron, \$230 per mo. with full maintenance. General Duty Nurses (2), \$200 per mo. with full maintenance, for 20-bed hospital.** Modern nurses' home. Usual holidays with pay & sick leave, etc. Apply stating salary desired to Matron, Union Hospital, Vanguard, Sask.



**REQUIRED IMMEDIATELY**  
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**General Staff Nurses, All departments**  
**(\$225 per mo. plus laundry)**

New 300-bed General Hospital. Excellent Personnel Policies.

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**Psychiatric Nurse** to assume position as Head Nurse & Clinical Supervisor of new 38-bed Psychiatric Unit in a 500-bed General Hospital. An excellent opportunity for a Psychiatric Nurse who wishes to assume leadership in developing the policies, procedures & teaching program of this new Psychiatric Unit. Patients treated only by psychiatrists. The most modern facilities & treatment methods. Cooperative administration. Bachelor's Degree required plus Psychiatric experience. Salary commensurate with experience & abilities. Write Director of Nursing, Aultman Hospital, Canton, Ohio.

**Assistant Evening & Night Supervisor** for 115-bed hospital with school of nursing. Moving to new hospital at end of year. Apply Director of Nursing, Children's Hospital, Winnipeg, Man.

**Training School Instructor** for new modern 238-bed hospital. Salary commensurate with qualifications. Apply Aberdeen Hospital, New Glasgow, Nova Scotia.

**McKellar General Hospital, Fort William, Ont. requires Clinical Instructor** in operating room. Gross salary commensurate with experience, 28 days vacation after 1 yr., 8 statutory holidays, sick leave accumulative to 60 days. Residence accommodation available at reasonable rates. Hospital has recently completed a well equipped & staffed wing with extensive renovation program progressing in the old section. Apply Director of Nursing.

**Instructor in science (1) & medical-surgical (1) for Aug.** Excellent personnel policies. Apply Director of Nurses, St. Joseph's Hospital, North Bay, Ontario.

**Science Instructor for School of Nursing.** Duties to commence August 1st. Apply Director of Nursing, Civic Hospital, Ottawa 3, Ont.

**Instructors (Surgery, Pediatrics & Public Health) for School of Nursing — 50 students.** (1 class per yr.) Personnel policies based on R.N.A.O. recommendations. For full details apply Director of Nursing, General Hospital, Port Arthur, Ontario.

**Science Instructor for August 1st.** 1 class yearly, approx. 25 students. Apply Director of Nursing, Children's Hospital, Winnipeg, Man.

**Instructor** for school of nursing — Applications are invited for 138-bed hospital. This school is affiliated with Montreal hospitals, the teaching schools associated with McGill University. For particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

**Nursing Arts Instructor** for School of Nursing, with capacity 195 students, attached to expanding hospital of 571 beds. B.S. Degree in Nursing Education preferred or at least 3 yrs. experience & working toward degree. Located in "All American City" of 120,000 in North Eastern Ohio with educational, industrial, recreational & agricultural primary interests. Salary commensurate with qualifications. Write Director of Nursing, Aultman Hospital, Canton, Ohio.

**Obstetrical Clinical Instructor** for School of Nursing with capacity 195 students attached to expanding hospital of 571 beds. B.S. Degree in Nursing Education preferred or at least 3 yrs. experience & working towards degree. Located in "all American City" of 120,000 in North Eastern Ohio with educational, industrial, recreational & agricultural primary interests. Salary commensurate with qualifications. Write Director of Nursing, Aultman Hospital, Canton, Ohio.

**Assistant Head Nurses & Staff Nurses** for children's orthopedic hospital. Good personnel policies. Apply Director, Shriner's Hospital for Crippled Children, 1529 Cedar Ave., Montreal, Quebec.



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for

200-bed hospital

Pleasant city of 38,000. Three colleges.

Good salary and personnel policy.

For further information apply to:

**DIRECTOR OF NURSES, GENERAL HOSPITAL, GUELPH, ONTARIO**

**Registered General Duty Nurses (2) for 76-bed fully modern hospital** on C.P.R. main line & Trans-Canada Highway to Calgary & Banff. Gross salary: \$205 per mo. Perquisites \$30. \$5.00 increment every 6 mo. 8-hr. day, 44-hr. wk. 1 mo. annual vacation with pay. Sick leave with pay. Apply Matron, Municipal Hospital, Brooks, Alta.

**Registered Nurses (2) immediately for 30-bed hospital** within 1 hr. drive from Waterton National Park, 1/2 hr. from Lethbridge & 4 hrs. from Calgary & Great Falls, Montana. Salary: \$175 per mo. plus full maintenance. 8 hr. shift (rotating). 44 hr. wk. 3-wk. vacation with pay after 1 yr. All statutory holidays. Apply Matron, Municipal Hospital, Magrath, Alta.

**Registered General Duty Nurses (3) for 19-bed hospital** in oil town 95 mi. S.W. of Edmonton. Close to Sylvan & Gull Lakes. Daily bus service to Edmonton. Salary: \$200 per mo. plus maintenance & laundry. \$5.00 raise every 6 mo. for 2 yrs. 44-hr. wk. Apply giving full particulars to the Matron, Municipal Hospital, Rimbey, Alta.

**Registered Nurses (2) for new 30-bed hospital.** Apply Matron, Creston Valley Hospital, Creston, British Columbia.

**Registered Nurses** for 18-bed General Hospital. Salary: \$225 less \$30 for full maintenance. 44-hr. wk., 10 statutory holidays. Beautiful part of B.C. Apply Matron, Arrow Lakes Hospital, Nakusp, B.C.

**Registered Nurses for new 65-bed hospital**, 25 mi. north of Winnipeg. Hourly bus service. Salary: \$195-215. \$10 differential for evening & night duty. Accommodation available in new residence with T.V. Usual personnel policies. Apply Supt. General Hospital, Selkirk, Manitoba.

**Registered Nurses (2) for 42-bed General Hospital.** Salary: \$210-\$230 per mo. Excellent accommodation in residence at \$30 per mo. 44-hr. wk. Usual holiday & sick leave benefits. Copy of personnel policy will be mailed upon request. Apply Supt. of Nurses, Bethesda Hospital, Steinbach, Man.

**Registered Nurses.** Single room residence. \$225 per mo. gross. 5 day wk. 20 mi. east of Toronto. Apply Supt. Ajax & Pickering General Hospital, Ajax, Ont.

**Registered General Duty Nurses for Obstetrical, Surgical & Medical Departments.** 8-hr. duty, rotating shifts. For further information apply Director of Nursing Service, St. Vincent de Paul Hospital, Brockville, Ontario.

**Registered Nurses.** Gross salary for nurses currently registered in Ont. \$235 per mo. Good personnel policies. New facilities. Comfortable nurses' residence. 8-hr. rotating shift. 44-hr. wk. 1 day off 1 wk., 2 the next. 1 1/2 days holiday allowed per mo. same sick time accumulated to 90 days. 8 legal holidays per yr. The equivalent of single train fare paid up to \$40 after 1 yr. service. Apply Supt., Lady Minto Hospital, Cochrane, Ont.

**Registered General Duty Nurses** for new 58-bed hospital situated in North Western Ontario. Opening about Sept. 1, 1956. Salary: \$215 per mo. subject to increase after 6-mo. with regular annual increase thereafter. \$45 per mo. room & board. 30 days vacation & rail fare refunded after 1 yr. service. New 21-bed nurses' residence, each room having an adjoining bathroom. Apply stating age & when available to Frederick Taylor, Administrator, Dist. General Hospital, Dryden, Ont.

**Registered General Duty & Operating Room Nurses for 25-bed hospital.** Starting salary: \$190-\$210, reg. increases. For further information apply Supt. Englehart & District Hospital Inc., Englehart, Ont.

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**Prerequisite 1-year course in Nursing Education**

Allowance made for degree if experienced. Student enrollment approximately 75. 1 class per year enters in September. Teaching staff of Director of Nursing Education & 4 Instructors. New school & residence to be ready for occupancy in 1957. Guelph is a pleasant city of 38,000. 3 Colleges. Good salary & personnel policies.

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**DIRECTOR OF NURSES, GENERAL HOSPITAL, GUELPH, ONTARIO**

**Registered Nurses for General Duty.** Initial salary: \$200 per mo.; with 6 or more months Psychiatric experience, \$210 per mo. Salary increase at end of 1 yr. 44-hr. wk.; 8 statutory holidays, annual vacation with pay. Living accommodation if desired. For further information apply Supt. of Nurses, Homewood Sanitarium, Guelph, Ont.

**Registered Nurse (Immediately)** with experience in Dietetics. For more information write Director of Nurses, Misericordia Hospital, Haileybury, Ontario.

**Registered General Duty Nurse for active 15-bed hospital.** Salary: \$200 per mo. with board & residence. Vacation, statutory holidays & sick leave benefits. Apply Administrator, District Hospital, Shelburne, Ontario.

**Registered General Duty Nurses for 200-bed hospital in the Niagara Peninsula.** Gross salary \$210, afternoons — \$220, nights — \$215. Annual increments. 44-hr. wk. 3-wk. vacation per yr., 8 statutory holidays. Cumulative sick leave. Accommodation available in attractive residence. Apply Director of Nursing, County General Hospital, Welland, Ont.

**Reg'd. Nurses for modern 60-bed General Hospital situated 40 mi. south of Montreal.** Salary: \$200 per mo., additional monthly bonus for permanent evening & night shifts. 44-hr. wk., 8-hr. duty. Many attractive benefits provided. Board & accommodation available at minimum cost in completely new motel-style nurses' residence. Apply Supt., Barrie Memorial Hospital, Ormstown, Que.

**Registered Nurses for 28-bed hospital, 48 mi. southeast of Montreal.** Salary \$150 per mo. \$500 increment every 6 mo. to maximum \$165 plus full maintenance. 1 mo. annual vacation with pay, all statutory holidays, 2 wk. sick leave, Blue Cross paid. 8-hr. day, rotating shifts. Wonderful summer resort 8 mi. from Lake St. Francis. T.V. in nurses' residence. Apply Mrs. M. G. Curran, County Hospital, Huntingdon, Que.

**Registered Nurses for 82-bed accredited hospital.** Gross salary \$210-\$230 per mo. 5½ day wk. with no split shifts. 30 days vacation with pay after 1 yr. service. Statutory holidays. Room in comfortable residence & laundry of uniforms provided at \$8.00 to \$12 per mo. Apply Supt. of Nurses, Union Hospital, Canora, Sask.

**Registered Nurses. Male & Female.** Starting salary: \$300 up, plus \$10 pm shifts. 40-hr. wk., paid vacation, 10 days sick leave. Social Security, hospital group ins. Apply Mr. Glenn A. Dickau, R.N., Administrator, Memorial Hospital, Corning, California.

**Registered General Duty Nurses for 118-bed General Hospital along the shores of Lake Michigan, 25 mi. from Chicago.** Base salary: \$300. Additional differential of \$30 for evenings & \$20 for nights. 5 day wk. Good personnel policies. Apply Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

**Registered Staff Nurses,** immediate appointments, in 511-bed newly enlarged and finely equipped general hospital. Duty assignments in medical, surgical, pediatrics, psychiatric, obstetrics, or contagion units. Northeastern Ohio stable "All-American City" of 120,000. In centre of area of recreational, industrial, and educational friendly activities. Living costs reasonable. Within pleasant driving-distance advantages of metropolitan Cleveland and Columbus, Ohio and Pittsburg, Pa. Friendly, cooperative work relations and conditions. Progressively advanced personnel policies. Starting salary: \$240 per mo. with 4 merit increases. Paid vacation, sick leave, recognized holidays, premium pay, sickness insurance and hospitalization program, retirement. Contact: Director of Personnel, Aultman Hospital, Canton, Ohio, by letter or collect telephone 4-5673.



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**Where?** Jeffery Hale's Hospital

**Why Unique?** Only English speaking hospital & training school in Quebec City

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**DIRECTOR OF NURSES, JEFFERY HALE'S HOSPITAL, 1250 ST. FOY, QUEBEC, P.Q.**

**Registered Nurses for 284-bed General Hospital** with vacancies in most departments including Psychiatry. Opportunity for advancement. Located on the beautiful Corpus Christi Bay in Texas which is a pleasant tropical climate. Positions available for (1) **Supervisors**, salary: \$280-\$315 per mo. (2) **General Staff**, starting salary: \$250-\$275 according to experience plus \$10 differential for evening or night shifts. Liberal personnel policies, 40-hr. wk. & \$50 transportation allowance. Apply Director of Nursing Service, Memorial Hospital, P.O. Box 5008, Corpus Christi, Texas.

**General Duty Nurses (3) immediately for 30-bed hospital.** Located in a good town 80 mi. east of Calgary on the CPR main line & the Trans Canada Highway. Salary: \$170 per mo. with full maintenance. Increases every 6 mo. 48-hr. wk. 8-hr. rotating shift. Apply by letter or wire for details of our staff plan to Mrs. H. Hislop, Matron, Municipal Hospital, Bassano, Alta.

**General Duty Nurses for 110-bed General Hospital** situated in the beautiful Fraser Valley, 68 mi. from Vancouver. Good bus service. Salary: \$230 per mo. Personnel policies in accordance with R.N.A.B.C. agreement. 40-hr. wk. Residence accommodation. Apply Director of Nursing, General Hospital, Chilliwack, B.C.

**General Duty Nurses.** Salary: \$230-270, \$10 increment for experience. 40-hr. wk. 1½ days sick leave per mo. cumulative; 10 statutory holidays, (1) mo. vacation. Must be eligible for B.C. registration. Apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

**General Duty Nurses (3) for 27-bed Community Hospital.** Salary: \$230 per mo. with annual increments of \$5.00 per mo. 40-hr. wk. 28 days vacation after 1 yr. service. All statutory holidays paid. Room, board & laundry \$40 per mo. Apply, giving full details, Matron, Slocan Community Hospital, New Denver, B.C.

**General Duty Nurses for 430-bed hospital;** 40-hr. wk. Statutory holidays. Salary: \$235-268. Credit for past experience. Annual increments; cumulative sick leave; 28 days annual vacation; B.C. registration required. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

**Royal Jubilee Hospital, Victoria, B.C.** invites applications for **General Duty Nurses** for permanent positions & vacation relief in 500-bed General Hospital. Salary \$227.50-\$262.50. 5-day, 40-hr. wk. 4-wk. vacation. 10 statutory holidays. Pension plan. Attractive employee benefits. Apply, Director of Nursing.

**General Duty Nurses for Medical, Surgical, Pediatrics, Obstetrics.** Good salary & personnel policies. Apply Director of Nursing, Victoria Hospital, London, Ont.

## **GENERAL STAFF and PSYCHIATRIC NURSES**

*Required to staff*

**New wing of 350-bed General Hospital.**

**Basic salary: \$250 per mo. with yearly increments of \$120 for 3 years.**

**Differential for evening & night duty.**

*For further information apply to:*

**DIRECTOR OF NURSING SERVICES, METROPOLITAN GENERAL HOSPITAL  
1995 LENS AVENUE, WINDSOR, ONTARIO**



## CANADIAN RED CROSS SOCIETY

invites applications for **STAFF and ADMINISTRATIVE** positions in **HOSPITAL, PUBLIC HEALTH NURSING SERVICES, and BLOOD TRANSFUSION SERVICE** for various parts of Canada.

- The majority of opportunities are in **OUTPOST SERVICES** in British Columbia, Saskatchewan, Manitoba, Ontario, Quebec, New Brunswick, and Nova Scotia.
- Commensurate salaries for experience and qualifications. Transportation arrangements under certain circumstances. Bursaries are available for post-graduate study.

*For further particulars apply:*

**NATIONAL DIRECTOR, NURSING SERVICES, CANADIAN RED CROSS SOCIETY,  
95 WELLESLEY ST., TORONTO 5, ONTARIO.**

**Graduate Nurses (3)** for 24-bed hospital. Salary: \$230 per mo. if B.C. registered; less \$40 board, lodging, laundry. 1 mo. vacation after 1 yr. on full pay. 1½ days sick leave per mo. cumulative. Apply, stating experience to Matron, Terrace & District Hospital, Terrace, British Columbia.

**Graduate Nurses (General Staff Positions)** for General Hospital. Salary: \$235.50 per mo. as minimum & \$273.75 as maximum, plus shift differential for evening & night duty. 40-hr. wk. Temporary residence accommodation is available. Applicants not registered in B.C. should forward a letter of acceptance of registration in B.C. from the Registrar of Nurses, 2524 Cypress St., Vancouver, B.C. Please apply Personnel Dept., Vancouver General Hospital, Vancouver, B.C.

**Graduate Nurses & Dietician (1)** for new, very modern 88-bed hospital in a pleasant progressive town. Nurses salary: \$200 per mo. Annual increase \$10 per mo. for 3 yrs. 2-wk. shift rotation, bonus for night shifts. 1 hr. drive to Toronto & several resorts. Local swimming pool, bowling alleys, skating, theatres etc. Apply Director of Nurses, Dufferin Area Hospital, Orangeville, Ont.

**Graduate Nurses** for duty on Obstetrical, Medical & Surgical Wards. Personnel policies as recommended by the Assoc. of Nurses of the Prov. of Quebec. Please apply Director of Nursing, Queen Elizabeth Hospital of Montreal, 2100 Marlowe Ave., Montreal 28, Que.

**Graduate Nurse (Bilingual) with psychiatric experience preferred**, for private French family consisting of 2 adults & 5 children, 3 in school & 2 pre school age. Duties: Nurse companion with preventive care of the two younger ones, able to drive a car & willing to accompany any member of the family travelling especially during vacations. Necessary qualifications: Good character & ability to get along well with children essential. Please send references & salary expected. For further information communicate either by letter to Mr. Pierre Joron, 153 Price West, Chicoutimi, Que. or telephone LI 3-3487.

**General Staff Nurses** for 400-bed Medical & Surgical Sanatorium, fully approved student affiliation & postgraduate program. Full maintenance. Recreational facilities. Vacation with pay. Sick benefits after 1 yr. Blue Cross coverage. Attractive salary; 40-hr. wk. For further particulars apply Supt. of Nurses, Nova Scotia Sanatorium, Kentville, N.S.

**General Staff Nurses (immediately) for operating room.** Apply Director of Nursing, Civic Hospital, Ottawa 3, Ont.

**Staff Nurses for 600-bed General & Tuberculosis Hospitals with student programs.** In central valley, city of 108,000. State & Junior Colleges afford opportunity for advanced education. Salary \$300 with 4 annual increases to \$341. Full maintenance \$45 per mo. Liberal personnel policies. Apply Assoc. Director of Nursing Service, County General Hospital, Fresno, California.

**Staff Nurses for 500-bed General Hospital.** Beginning salary: \$300 per mo. with advancement to \$335 for those eligible for registration in the state of Michigan. Additional differential \$1.50 per afternoon or night. 40-hr. wk. Hospital & school of nursing fully approved. Apply Director of Nursing, The Grace Hospital, 4160 John R. St., Detroit 1, Michigan.

**Nurses** — Vacancies in all depts. in new hospital, located in same city with the large Warren Air Force Base. Come to "Wonderful Wyoming" to enjoy hunting, fishing, beautiful mountain trips to the Tetons, Yellowstone National Park & Rocky Mts. Salary commensurate with background, minimum \$265-\$300 per mo. 40-hr. wk. Apply Director of Nursing, De Paul Hospital, Cheyenne, Wyoming.

**Operating Room Nurses.** Good salary with credit given for experience or P.G. courses. 40-hr. wk. Liberal personnel policies. Apply Director of Nursing, Royal Jubilee Hospital, Victoria, B.C.

# DIRECTOR OF NURSING

## 350-BED GENERAL HOSPITAL      200 NURSING STUDENTS

Applications are invited for the position of Director of Nursing & Principal of School of Nursing. Good salary & personnel policies. Please furnish particulars of qualifications, experience & age.

*For further information write to:*

**GENERAL SUPERINTENDENT, CITY HOSPITAL,  
SASKATOON, SASKATCHEWAN.**

**Operating Room Nurse, postgraduate training not essential.** All graduate staff. A.N.P.Q. salary scale in effect. 8-hr. day, 5½ day wk. Apply Director of Nursing, Montreal Children's Hospital, Montreal, Que.

**Operating Room Nurses, immediate appointments, for 511-bed newly enlarged and finely equipped hospital; 10 operating rooms now completed.** Northeastern Ohio stable "All-American City" of 120,000. In centre of area of recreational, industrial and educational friendly activities; living cost reasonable. Within pleasant driving-distance advantages of metropolitan Cleveland and Columbus, Ohio, and Pittsburg, Pa. Friendly and considerate working associates and conditions. Progressively advanced personnel policies. Starting salary: \$240 per mo. with 4 merit increases. Paid vacation, sick leave, recognized holidays, premium pay, sickness insurance and hospitalization program, retirement. Contact Director of Personnel, Aultman Hospital, Canton, Ohio, by letter or collect telephone 4-5673.

**Surgical Nurses urgently needed by July for leading modern hospital.** Salary: \$275 plus benefits to \$325. Fee paid by employer. Excellent location with many recreational facilities. **R.N.'s to assist in doctor's offices & clinics. Lab. tech., serology background,** salary open. Apply Medical Placement Bureau, 1115 S. W. Yamhill, Portland, Oregon.

**Baker Memorial Sanatorium, Calgary, Alberta,** offers to Graduate Nurses a 6-mo. post-graduate course in Tuberculosis. Maintenance & salary as for general staff nurses. Opportunity for permanent employment if desired. Spring & Fall Classes. Further information on request.

**Supervisor (1), Public Health Staff Nurses (2) for generalized program** in city of 43,000. Blue Cross & P.S.I. employer shared. Transferrable accumulative sick leave & pension plans. Workmen's Compensation. Group ins. available. Transportation provided or allowance — 10¢ first 2,000 mi., 8¢ per mi. thereafter. 5-day wk. 1 mo. vacation with extra time at Christmas. Salary scales: (1) Supervisors, \$3,600-\$4,400 with annual increment of \$200. (2) Field Nurses, \$3,000 for inexperienced nurses to start with annual increments of \$150. All starting salaries dependent on experience. For further information please write supplying details of training & experience to Medical Officer of Health, City Hall, Peterborough, Ont.

**Public Health Nurse Grade 1.** British Columbia Civil Service, Dept. of Health & Welfare. Starting Salary \$255, \$260, \$266 per mo., depending on experience, rising to \$298. per mo. Promotional opportunities available. Qualifications: Candidate must be eligible for registration in British Columbia & have completed a University degree or Certificate course in Public Health Nursing. (Successful candidates may be required to serve in any part of the Province.) Cars are provided. 5-day wk. in most districts. Uniform allowance. Candidates must be British subjects; preference is given to ex-service women. Application forms obtainable from all Government Agencies, the Civil Service Commission, 544 Michigan St., Victoria, or 411 Dunsmuir St., Vancouver 3, to be completed & returned to the Chairman, Civil Service Commission, Victoria. Further information may be obtained from the Director, Public Health Nursing, Dept. of Health & Welfare, Parliament Bldgs., Victoria, B.C.

## GENERAL STAFF NURSES

For 526-bed General Hospital. Opportunity for advancement. Rotating or permanent evening & night assignments. 40-hr. wk., 6-hr. evening duty. Salary: \$260-\$300 with increase after 6 mo., 1 yr. & on merit thereafter. Evening & night bonus. Tuition assistance for university & college courses. 2 wk. vacation after 1 yr. service, 3 wk. after 2 yrs. Terminal vacation. 5-10 days sick leave after 1 yr. Uniforms laundered. Temporary housing in hospital residence at a nominal fee. Convenient transportation.

Apply **DIRECTOR OF NURSING SERVICE,**  
**SAINT LUKE'S HOSPITAL, 11311 SHAKER BLVD., CLEVELAND 4, OHIO**



# PEDIATRIC INSTRUCTOR

Responsible for classroom and clinical instruction in pediatric nursing & co-ordinating maternal & child care program in school where organizational set-up permits stressing of patient-centred care and student-centred learning activities.

*For further information apply:*

**DIRECTOR, SCHOOL OF NURSING, METROPOLITAN GENERAL HOSPITAL, WINDSOR, ONTARIO.**

**Public Health Nurse (Qualified) for Haldimand County, School Health Service.** University certificate in Public Health Nursing required. State qualifications, experience & salary expected. Apply E. B. McPherson, Lowbanks, Ont., telephone, Wainfleet 104 R-3.

**Public Health Nurses.** Duties to commence between June & Sept. 1956. Salary: \$2,796-\$3,396. 5-day wk. 1 mo. vacation. Pension plan. Apply Dr. W. H. Hill, M.O.H., Dept. of Health, Calgary, Alta.

**Public Health Nurses for generalized program** in rural-suburban Health Unit near Toronto. Minimum salary: \$3,000. Pension plan. For full details apply Supervisor, Peel County Health Unit, Court House, Brampton, Ont.

**Public Health Nurses (qualified) for generalized program.** Salary \$2,700 to \$3,200 depending on experience. Annual increment \$100. 5-day wk. Pension plan. Blue Cross & P.S.I. available. Car provided or car allowance. Apply Dr. Charlotte M. Horner, Director, Northumberland-Durham Health Unit, Cobourg, Ont.

**Public Health Nurses for Wentworth County Health Unit.** Generalized program. Minimum salary without experience \$2,800. 5-day wk. Pension plan. Blue Cross. Liberal car allowance. Apply stating qualifications, experience & salary expected to A. F. Stewart, County Clerk, National Revenue Bldg., Hamilton, Ont.

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**Public Health Nurse (1) for generalized program** in rural & semi-urban area adjacent to metropolitan Toronto. Excellent working conditions including pension plan, group ins. & transportation arrangements. Apply Dr. R. M. King, York County Health Unit, Newmarket, Ont.

**Public Health Nurses (qualified.)** Salary: \$3,100 depending on dist. served, less if in the Timmins area. Annual increment \$150 per annum for 4 yrs. Additional allowance for experience & if French-speaking. 5-day wk. 4-wk. vacation, 18 days sick leave annually (cumulative.) Car is provided. Half cost of uniform is allowed & half of Blue Cross. Workmen's Compensation. Good working conditions. Apply Sec.-Treas., Porcupine Health Unit, 164 Algonquin Blvd. E., Timmins, Ont.

## THE PROVINCE OF MANITOBA

*requires a*

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for the School for Mentally Defective Persons at Portage La Prairie, Manitoba. Applicants should be qualified in Psychiatric Nursing, registered Nurse preferred.

Experience or postgraduate study in administration would be an asset.

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**Nurse Technician (Immediately)** preferably trained for intravenous therapy, transfusions etc. Apply Asst. Supt., Civic Hospital, Ottawa, Ontario.

**General Duty Nurses (3), O.R. Scrub Nurse for new 143-adult bed plus 30-bassinette hospital.** Good personnel policies. Starting salary: \$215 per mo. Apply Director of Nurses, Plummer Memorial Hosp., Sault Ste. Marie, Ontario.

**Operating Room Supervisor. Operating Room Nurse, General Duty Nurses for 100-bed hospital in friendly resort town.** Excellent personnel policies. For information apply Director of Nursing, Norfolk General Hospital, Simcoe, Ontario.

**Superintendent (Sept. 1, 1956 or before) for modern 50-bed Community Hospital, 50 mi. from Ottawa.** Full maintenance. 1 mo. vacation with pay after 1 yr. service. 7 statutory holidays. Apply stating qualifications & references to Sec. to the Board, Pontiac Community Hospital, Shawville, Que.

**Science Instructor (1), Nursing Arts Instructor (1) for August.** 10-15 students per class. Salary: \$230 per mo. Apply Director of Nursing, General Hospital, Brandon, Manitoba.

**Registered Nurse,** ambitious to broaden knowledge in clinical laboratory, hematology, serology, chemistry & x-rays. Willing to complete American Med. Technician registration. Earning 3-wk. vacation, full expense convention trip. Live-in maintenance, uniforms laundered. Use of car, plus \$4,200 cash. Easily bettering \$6,600 annually or \$3.00 per hr. worked. (Tuition free.) Beautiful model small hospital & clinic. 18 mo. to 3 yr. contract. Apply Dr. Keyes, Keyes Dearborn Clinic & Diagnostic Hosp., 4840 Maple, Dearborn, Michigan.

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*Apply*

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WINNIPEG 13, MANITOBA.**

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*has openings for*

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TORONTO**

**WESTMINSTER HOSPITAL  
LONDON**

Application forms, available at your nearest Civil Service Commission Office, National Employment Service & Post Offices, should be forwarded to the

**CIVIL SERVICE COMMISSION,  
25 ST. CLAIR AVE. E., TORONTO 7, ONTARIO**

**General Duty Nurses** for all departments. Gross salary: \$210 per mo. if registered in Ontario \$200 per mo. until registration has been established. \$20 per mo. bonus for evening or night duty; annual increment of \$10 per mo. for 3 yrs. 44-hr. wk., 8 statutory holidays, 21 days vacation & 14 days leave for illness with pay after 1 yr. of employment. Apply: Director of Nursing. General Hospital, Oshawa, Ont.

**General Duty Nurses for modern 42-bed hospital.** Excellent equipment & facilities. Starting salary: \$225 per mo. Annual increments. Good personnel policies. Apply Supt. of Nurses, General Hospital, Sioux Lookout, Ont.

**General Duty Nurses** for 650-bed teaching hospital in central California. Salary: \$288-\$337 per mo. 40-hr. wk. Liberal vacation, holiday & sick leave plan. Apply Personnel Office, 510 E. Market St., Stockton, California.

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**Graduate Nurses (2)** for general duty. Salary: \$250 per mo. 8-hr. day, 5-day wk. Room & Board \$45 per mo. Transportation paid one way after 6-mo. service. Apply Matron, Queen Charlotte Islands Hospital, The United Church of Canada, Queen Charlotte City, B.C.

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**Public Health Nurses (Qualified) for generalized public health nursing service.** Salary range: \$3,186-\$3,618. Starting salary based on experience. Annual increments, 5-day wk., vacation, sick pay & pension plan benefits. Apply Personnel Dept., Room 320, City Hall, Toronto, Ont.

**Pediatric Supervisor (Experienced with postgraduate study)** for supervision of Children's Ward & Nursery in 100-bed hospital. Apply Director of Nurses, Royal Alexandra Hospital, Edmonton, Alberta.

**Geriatric Nursing Assistant with practical ideas.** Should be a graduate, not necessarily recent. Small privately endowed home in Maritimes with pleasant atmosphere. Apply Box B, The Canadian Nurse Journal, 1522 Sherbrooke St. W., Montreal 25, Que.

Interested in an 8-week Tour of Europe? Miss Viola Vandervoort, Surgical Instructor of Oshawa General Hospital, Oshawa, Ont. who is planning an 8-wk. vacation after the ICN Congress in 1957 in an English car she plans to purchase — it will be delivered either to London or Rome. — would like someone who would be interested in accompanying her & sharing expenses.



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CANADIAN INDUSTRIES LIMITED

# THE CANADIAN NURSE

## *L'Infirmière Canadienne*

VOLUME 52

NUMBER 8

AUGUST 1956

### 590 NEW PRODUCTS

597 TOMORROW'S PATTERN.....*Gladys J. Sharpe*

601 A SUMMARY OF CLINICAL  
LABORATORY PROCEDURES.....*E. M. Watson*

611 WHAT IT MEANS TO BE OLD.....*Elisabeth C. Phillips*

617 DIABETES MELLITUS.....*Mary Dersco*

### 624 NURSING PROFILES

### 626 IN MEMORIAM

627 WHEN A NURSE HAS DIABETES.....*Daphne Bell*

630 IMPRESSIONS D'AFRIQUE...*Claire (Desmarais) Tremblay*

### 634 SÉLECTION

636 A NEW DEAL FOR MALE NURSES.....*Albert Wedgery*

640 LIFE, PROFESSION AND SCHOOL.....*Sir Fred Clarke*

### 648 CANADIAN NURSE AWARD

### 649 NEWS NOTES

### 661 EMPLOYMENT OPPORTUNITIES

### 672 OFFICIAL DIRECTORY

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# Between Ourselves

AS IS CUSTOMARY in a Biennial Convention year, we are pleased to present the **presidential address**. In our lead article this month **Gladys J. Sharpe** reviews some of the highlights of the past biennium with an eye to their bearing on developments in Canadian nursing. Her duties as president of the Canadian Nurses' Association have called for extensive travelling. You have read and enjoyed the account of her trip to Istanbul, Turkey as one of our representatives to the Board of Directors' meeting of the I.C.N. A busy director of nurses, she has managed to crowd into an already-overflowing professional calendar, a record of accomplishments on our behalf that proves again the old adage — if you want something done, give it to a busy person.

\* \* \*

We are featuring the **summary of laboratory procedures** prepared by Dr. E. M. Watson this month. Elsewhere will be found a half-page form listing the prices for reprints of this material. It would expedite the ordering of these reprints very considerably if we could have some idea of the probable quantity that will be wanted. It is not necessary to send payment in advance. We will invoice purchasers when the reprints are sent out. But please give us some idea of quantity as quickly as possible.

Dr. Watson is Professor of Pathological Chemistry and Senior Associate in Medicine, Faculty of Medicine, University of Western Ontario, London. He is Clinical Pathologist at Victoria Hospital.

\* \* \*

The usual burst of **year books** from schools of nursing across the country is subsiding. Many of the copies that have been received are excellent, showing perseverance, originality and downright hard work. The numerous student editors are to be congratulated on their handiwork. We hope the schools will continue to share

copies with us each year. More than that! We hope these budding editors will continue to write after they have graduated and will share their material with their colleagues through the pages of *The Canadian Nurse*.

\* \* \*

More and more, in the items for News Notes that are received from districts, chapters and alumnae associations, it would appear that discussions on topics of pertinent interest are superseding the formal lectures as program. A very useful booklet entitled "Putting Words to Work" has recently been published by the Canadian Association for Adult Education. It is our feeling, after reading through this 23-page booklet, that it would be a distinct advantage for every association to have a copy of this guide to **effective group discussion**. Copies may be obtained from C.A.A.E., 113 St. George St., Toronto, Ont., for 50 cents each.

It will be a great day for our professional associations when *every* nurse has acquired at least a modicum of skill in phrasing questions easily, in marshalling her thoughts in orderly fashion, in talking *at* meetings instead of afterwards. As in so many other things practice is the key that will unlock previously closed lips, that will take that icy feeling away from the pit of the stomach, that will produce new thinking and leadership among the members of our profession. Let us have *more* discussion groups, *more* intelligent and realistic reasoning of our common problems. This booklet is a good starting point.

\* \* \*

One of the old reliable sections of the *Journal* is not included this month. Pressure of work has prevented the secretaries at National Office from preparing the customary items of interest regarding "Nursing Across the Nation." We look forward to resuming this section and its companion "Le Nursing à travers le Pays" next month.

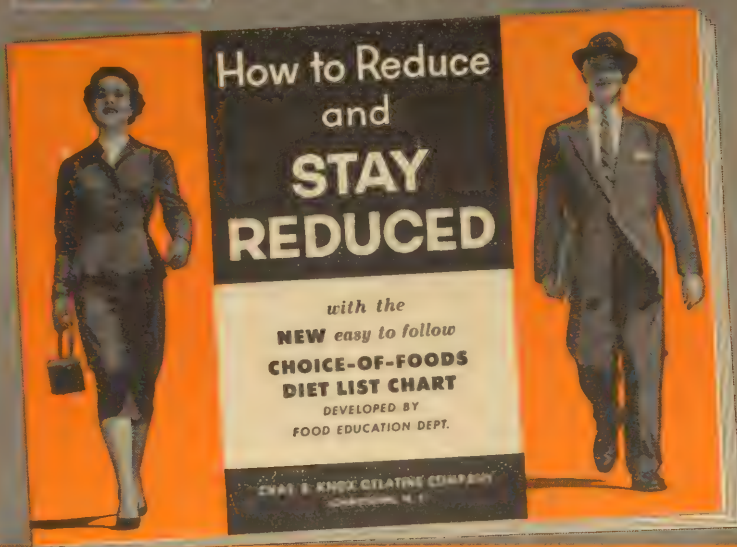
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Self-restraint; self-discipline; resolute determination to preserve the good manners, the decencies, the cultural traditions of our society; a kindling of the civilized conscience; esteem for the integrity of the honorable dissenter; dispersion of power rather than concentration of power; freedom to apply one's industry according to one's

talents; freedom to possess and enjoy the benefits of property, to save and to invest, to spend and to lose; freedom to seek redress from injustice; freedom to worship the God of one's own choice, and freedom to think one's thoughts and to speak one's mind — these are the indivisible elements of a free society. — LEWIS W. DOUGLAS

**KNOX**

# Protein Previews



## New Booklet Available to Aid Management of Overweight Patients



The 1955 edition of the well-known Knox "Eat-and-Reduce" booklet eliminates calorie counting for obese patients under your care. This year's edition is based on the use of Food Exchange Lists<sup>1</sup> which have proved so accurate in the dietary management of diabetics.

The first 18 pages of the new booklet present in simple terms key information on the use of Food Exchanges (referred to in the book as Choices). In the center, double gatefold pages outline color-coded diets of 1200, 1600, and 1800 calories based on the Food Exchanges.

To help patients persevere in their reducing plans, the last 14 pages of the new Knox booklet are devoted to more

than six dozen, *tested*, low-calorie recipes. Use the coupon below to obtain copies of the new "Eat-and-Reduce" booklet.

1. Developed by the U.S. Public Health Service assisted by committees of The American Diabetes Association, Inc. and The American Dietetic Association.

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# New Products

Edited by DEAN F. N. HUGHES

PUBLISHED THROUGH COURTESY OF *Canadian Pharmaceutical Journal*

## CENTRINE INJECTION

**Manufacturer**—Bristol Laboratories of Canada Limited, Montreal, P.Q.

**Description**—A prepared, sterile, stable solution containing in each cc.: Centrine dihydrogen citrate (aminopentamide) 0.5 mg.

**Indications**—As a substitute for atropine sulfate, in all indications of parenteral atropine. Particularly useful in cases which are known or suspected to have atropine sensitivity.

**Administration**—The usual dose is 0.5 mg., repeated if necessary in 3 to 4 hours.

## COLACE

**Manufacturer**—Mead Johnson & Company of Canada, Limited, Toronto and Belleville, Ont.

**Description**—**Capsules**: Each capsule contains 50 mg. of dioctyl sodium sulfosuccinate

**Liquid**: Colace liquid is a 1% solution containing 10 mg. dioctyl sodium sulfosuccinate in each cc.

**Indications**—A gentle-acting stool-softener for use in treating and avoiding constipation.

**Administration**—**Capsules**: 1 capsule daily, or as prescribed.

**Liquid**: Infants and children under 3: as prescribed by physician. Children 3 to 6: 1 cc. 1 to 3 times daily, or as prescribed.

Administered by unbreakable plastic calibrated soft-dropper.

## CORICIDIN FORTE CAPSULES

**Manufacturer**—Schering Corporation Ltd., Montreal, P.Q.

**Description**—Each capsule contains: 4 mg. chlorphenpyridamine maleate, 190 mg. salicylamide, 130 mg. phenacetin, 30 mg. caffeine, 50 mg. ascorbic acid, 1.25 mg. methamphetamine hydrochloride.

**Indications**—For intensified therapy of the common cold rapidly controlling local reactions, such as lacrimation, sneezing, nasal discharge, and congestion as well as constitutional symptoms including malaise, general aches and pain, chills and fever.

**Administration**—One capsule every 4 to 6 hours.

## CYTOFERIN

**Manufacturer**—Ayerst, McKenna & Harrison, Ltd., Montreal.

**Description**—Each tablet provides: Ferrous sulphate B. P. 324 mg., vitamin C, 150 mg.

**Indications**—As a readily available source of iron in microcytic hypochromic anemias.

**Administration**—One tablet 2 or 3 times daily preferably with meals.

## DRAPOLENE

**Manufacturer**—Calmic Limited, 309-310 Terminal Bldg., York St., Toronto, Ont.

**Description**—Benzalkonium Chloride 0.01% in soothing water-miscible base.

**Indications**—Diaper rash, urinary dermatitis — prevention and treatment.

**Use**—Apply after diaper change, making certain that all traces of soap are removed from the skin.

## FLEXIN

**Manufacturer**—McNeil Laboratories, Inc.; **Can. Dist.**: Van Zant & Company, Toronto, Ont.

**Description**—2-amino-5-chlorobenzoxazole.

**Indications**—Musculoskeletal disorders.

**Administration**—Adults: One to 2 tablets (250 to 500 mg.) 3 or 4 times a day with food or immediately after meals. Children: One tablet (250 mg.) 2 to 4 times a day.

## SABOL

**Manufacturer**—Frank W. Horner Limited, Montreal.

**Description**—A new, extremely effective bactericidal treatment for infectious dandruff.

1. Cleanses the hair and scalp.

2. Destroys the organisms associated with infectious dandruff.

**Indications**—For infectious dandruff and seborrheic dermatitis.

**Administration**—Wet hair thoroughly, massage  $\frac{1}{4}$  to  $\frac{1}{2}$  oz. sabol into the scalp for 2 to 3 minutes and rinse. Repeat application, rinse, dry, and brush. In most cases, one Sabol treatment a week is required in order to keep the scalp free from dandruff.

To prevent reinfection, brush and comb should be washed in a solution of Sabol — 1 or 2 teaspoonfuls to a glass of water.

*The Journal presents pharmaceuticals for information. Nurses understand that only a physician may prescribe.*



# Price list for Reprints

A new edition of Dr. E. M. Watson's  
**Summary of Clinical Laboratory Procedures**  
will be available after August 15, 1956.

## Prices:

Single copies .....	10 cents
One dozen copies .....	\$1.00
25 to 100 copies .....	8 cents each
Over 100 copies .....	6 cents each

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Amount Enclosed .....

## GRAVOL LONG ACTING

**Manufacturer**—Frank W. Horner Limited, Montreal, Que.

**Description**—Each long acting capsule contains granules with different disintegrating times. Thus they provide relief from nausea and vomiting for prolonged periods. Each capsule supplies 75 mg. gravol (dimanhydrinate) — 25 mg. for immediate release and 50 mg. for prolonged release.

**Indications**—Nausea and vomiting of pregnancy; extended travel; any condition requiring prolonged treatment.

**Administration**—Nausea and vomiting of pregnancy — one capsule at bedtime and one on awakening. Repeated as required. Other indications — one capsule as directed.

## NEO-CORTEF LOTION 1%

**Manufacturer**—The Upjohn Company of Canada, Toronto, Ont.

**Description**—Each cc. contains: Hydrocortisone acetate 10 mg., neomycin sulphate 5 mg., methylparabex 2 mg., butyl-p-hydroxybenzoate 3 mg.

**Indications**—For topical application as an anti-inflammatory and anti-infective preparation.

## TOLERIN

**Manufacturer**—Anglo-Canadian Drug Co. Ltd., Oshawa, Ont.

**Description**—Each tablet contains 5 gr. acetylsalicylic acid buffered with a balanced colloidal aluminium-magnesium gel.

**Indications**—For salicylate therapy of rheumatic diseases, where relatively large doses are required over long periods, with a minimum of gastric disturbance.

**Administration**—In rheumatic diseases, usual daily dosage is a total of 8 to 12 tablets, in divided doses of 2 tablets every 3 or 4 hours. As an analgesic and antipyretic, 1 to 3 tablets is the usual single adult dose.

## TRIDAL

**Manufacturer**—Lakeside Laboratories (Canada) Ltd., Toronto, Ont.

**Description**—N-ethyl-3-piperidyl-diphenylacetate HCl 50 mg.; N-ethyl-3-piperidyl-benzilate methobromide 5 mg., white unscored tablets.

**Indications**—Gastrointestinal disorders such as: nervous indigestion, gastrointestinal cramps, flatulence, hypermotility, hyperacidity, colonic spasm.

**Administration**—As prescribed, usually 1 tablet 2 or 3 times daily and at bedtime, to be swallowed quickly with water.

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For additional information, write to:

**School of Nursing, Hamilton College,  
McMaster University, Hamilton, Ontario.**

#### METICORTELONE ACETATE

**Manufacturer**—Schering Corporation Limited, Montreal, Que.

**Description**—Prednisolone acetate 25 mg. per cc. suspended in saline solution.

**Indications**—Designed expressly for localized intra-articular therapy of rheumatoid arthritis, osteoarthritis and posttraumatic bursitis. Pain and joint stiffness generally are relieved within 24 hours, benefits lasting for an average of eight days up to several weeks in some cases. The new sterile corticoid suspension is particularly useful: (1) when only one or two peripheral joints are involved; (2) when treating resistant or severely involved joints during systemic therapy; (3) when systemic therapy with gold, ACTH or corticosteroids is ineffective or contraindicated; (4) when joint surgery is required; and (5) when indicated to decrease the severity of relapse in one or several joints. Also indicated for intramuscular use where oral therapy is not possible.

**Administration**—Intra-articular. The average dosage for larger joints is 25 mg. (1 cc.) while 10 to 15 mg. usually is sufficient for smaller joints. Severely inflamed joints may require one or more injections a week. Intrasynovial or intrabursal injections are particularly suitable for the knee, shoulder, elbow, wrist, ankle, phalangeal joints and bursae. In acute bursitis a single injection of 25 mg. (1 cc.) or occasionally 37.5 mg. (1.5 cc.) usually is sufficient for complete relief. A second injection may be given in 3 to 5 days as required.

**Intramuscular**—The average dosage for initial suppression of symptoms is 30 mg. daily, divided equally into three doses. When symptoms have been controlled, this dosage may be reduced 2½-5 mg. daily until maintenance therapy has been determined.

The only way to diet successfully is to cut down on the total intake of food, not to cut out one or two specific foods in the mistaken belief that these are somehow the villains of the piece. By the same token that no one food is "fattening" by itself when taken in sensible amounts, there is no such thing as a "reducing" food — that's a contradiction in terms. Too much of any food — even

rare steak broiled to a fine turn — can contribute to overweight just as surely as too much of anything else. But such foods as these have escaped the blanket condemnation that bread, potatoes and sugar have received — perhaps because they are generally more expensive and consequently eaten less.

— STARE & LYONS in  
*McCalls Magazine*

## PSYCHIATRIC NURSING COURSE

The ALLAN MEMORIAL INSTITUTE OF PSYCHIATRY OF THE ROYAL VICTORIA HOSPITAL offers six-month courses in Theory and Practice in *Psychiatric Nursing to Graduate Nurses* in good standing in their own province.

Classes — Spring and Fall.

Complete maintenance or living-out allowance, meals in hospital and uniform laundry for the first three months. General duty rates the second three months.

*For further information write to:*

Miss H. M. Lamont, Director of Nursing, Royal Victoria Hospital, Montreal 2, Que. or Miss Kathleen Marshall, Supervisor of Nurses, Allan Memorial Institute of Psychiatry, Royal Victoria Hospital, Montreal 2, Que.

## ROYAL VICTORIA HOSPITAL

School of Nursing, Montreal

### COURSES FOR GRADUATE NURSES

1. A four-month clinical course in *Obstetrical Nursing*.
2. A two-month clinical course in *Gynecological Nursing*.

**Salary**—After second month at General Staff rates.

*For information apply to:*

Director of Nursing  
Royal Victoria Hospital  
Montreal 2, Que.

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*Available in handy tubes for your purse, and in economy size for home use.*

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## PSYCHIATRIC NURSING COURSE

The Hospital for Mental Diseases, Brandon, Manitoba, offers a 6-month Diploma Course in Psychiatric Nursing to Registered Nurses.

Applicants accepted in September of each year. Salary while taking course: \$205 per mo. less \$25 per mo. for full maintenance.

Upon completion of course nurses are eligible for positions on Permanent Staff.

*For further information apply:*

Superintendent of Nurses,  
Hospital for Mental Diseases,  
Brandon, Manitoba.

## THE WINNIPEG GENERAL HOSPITAL

Offers to qualified **Registered Graduate Nurses** the following opportunities for advanced preparation:

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2. A six-month *Clinical Course in Operating Room Principles and Advanced Practice.*

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*For further information please write to:*

**DIRECTOR OF NURSING  
GENERAL HOSPITAL  
WINNIPEG, MANITOBA**

## NOVA SCOTIA SANATORIUM KENTVILLE N.S.

Offers to Graduate Nurses a Six-Month Course in *Tuberculosis Nursing*, including Immunology, Prevention, Medical & Surgical Treatment.

1. Full series of lectures by Medical and Surgical staff.
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3. Experience in Thoracic Operating Room and Postoperative Unit.
4. Full maintenance, salary & all staff privileges.
5. Classes start May 1st and November 1st.

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SANATORIUM, KENTVILLE, N.S.**

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THE NOVA SCOTIA HOSPITAL offers to qualified Graduate Nurses a six-month certificate course in *Psychiatric Nursing*.

- Classes in June and December.
- Remuneration and maintenance.

*For further information apply to:*

**Superintendent of Nurses  
Nova Scotia Hospital  
Drawer 350  
Dartmouth, Nova Scotia**



## The Pediatric Nurse

Taking charge of a band of "wild frontiersmen" can be as difficult as trying to put your finger on a drop of mercury. But that's the way children are, bless 'em, and we bet you wouldn't trade wards with anyone!

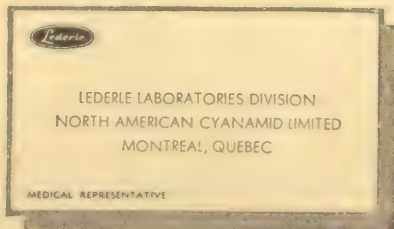
This same devotion to duty also makes us believe you are interested in knowing more about the drugs you regularly administer—products like these:

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**VARIDASE\*** Streptokinase-Streptodornase, a versatile enzyme used for wound debridement and for control of inflammation.

**FOLBESYN\***Vitamins, a high-potency parenteral B-Compound with C.

The easiest way to get such information is to talk with the Lederle detail man whenever you have a few minutes to spare. Why not contact him today through your hospital pharmacy?



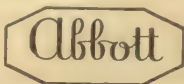


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# THE CANADIAN NURSE

## *L'Infirmière Canadienne*

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## Tomorrow's Pattern

### *Presidential Address*

TWO YEARS HAVE ELAPSED since this gavel, presented by the Association of Nurses of Bermuda was placed in my hand. On that occasion the wish was expressed that the development of our program would be such as to keep pace with the changing needs of society. The following lines were quoted:

This is the present the past built  
Thought by thought, stone by stone.  
We may pick the past apart  
But we may not change it.

In harmony with this theme I would recall a few "thoughts of the past" which have become the foundation stones of our present — then proceed to follow the theme as suggested in the final paragraph of the quotation:

Ahead is the future the present will build.  
Each thought that is thought today,  
Each stone that is laid today,  
Whatever the past has taught us,  
Whatever the present discloses,  
All these combine to form tomorrow's pattern.

While our professional history covers 56 years, these thoughts of the past will be confined to the preceding six.

The first "thought" takes us to March 19, 1955 when we learned of

the peaceful passing of a beloved friend and past president of this Association, Miss Marion Lindeburgh. No finer tribute could be paid than that contained in the citation read at the time the University of British Columbia conferred on her the degree of Doctor of Science.

She has brought selfless devotion, in-



(Ashley & Crippen - Toronto)

GLADYS J. SHARP

finite persistence and rare distinction of mind and character to her lifetime task of advancing the art and science of nursing. The Senate of this University pays tribute to her unconquerable spirit, her prominence in this field and gladly acknowledges the debt which contemporary nursing education owes her.

Let us reflect on the steps by which contemporary nursing education is attempting to discharge its debt to one of its most inspiring leaders.

**Act I:** Time — June, 1950.

**Scene:** The campus of the University of British Columbia — in view of the snow-capped peaks of the coastal range.

Here by unanimous agreement it was decided "to take a good look at ourselves." With Miss Florence Emory as chairman, a committee was formed and by its terms of reference directed to re-examine, study, consider and survey the structure and services of our Association. To be explicit, instructions for committee action were:

1. To re-examine the purposes of a national professional organization and the functions necessary to achieve these purposes.

2. To study the interrelationships of the national and the provincial associations.

3. To consider the relation of the purposes and functions of the Canadian Nurses' Association to the nurse and society including the relationship to other organizations working in the field of health and welfare.

4. To survey the existing machinery and personnel with a view to a more adequate fulfillment of these purposes, functions and relationships.

January, 1951 saw the study launched and January, 1952 marked its completion under the directorship of Dr. Pauline Jewett.

**Act II:** Time — June 1952.

**Scene:** The old-world French atmosphere of the Chateau Frontenac in Quebec City.

The report of the Structure Study Committee was presented to the members. While many voting delegates were ready to support the proposed recommendations and while there was general agreement as to the principles involved, there were many indications that action should be delayed. We supported in effect the wisdom of Dr.

Brock Chisholm's philosophy that it is not profitable to be defeated in trying to bring about *at once* changes that will take — and we paraphrase — a biennium to accomplish.

**Act III:** Time — June, 1954.

**Scene:** The majestic beauty of the Rocky Mountains viewed from the Banff Springs Hotel.

So thoroughly was the report of the Structure Study Committee considered by chapters, special groups, districts and provincial associations in the intervening 24 months and so clearly had the Committee on Constitution and Bylaws portrayed the change in our organizational structure, that the proposed bylaws in the final report of the Structure Study Committee were accepted with but one alteration. By this open-minded approach on the part of all members, the association marched forward another milestone towards professional maturity.

**Act IV:** Time — June, 1956.

**Scene:** Once again the environs of higher education — the beautiful campus of the University of Manitoba.

The business before us consists of receiving, reviewing, rejecting or honoring "accounts rendered" by those in whom you vested the responsibility for conducting the affairs of this Association during the past biennium. In common with other professional associations the Canadian Nurses' Association has two major objectives: To promote the best interests of the members of the profession and to promote the best interests of the public generally. In addition the Canadian Nurses' Association has a third important objective: To promote the best interests of the International Nurses' Association.

Prerequisites to the attainment of any objective are sound planning and coordinated action. Our organization is too large, our distances too great and our meetings too brief to do more than *plan* for the work to be done, *outline* general policies for doing it and *make final decisions*. The work itself must be delegated to committees and in certain instances to subcommittees. Committees then are the working units or machinery of any organization. In terms of the new bylaws, the committee structure of our Association was extensively revised.



Consequently this past biennium saw the principle of horizontal structure replace that of vertical. In other words, instead of concerning itself with matters affecting a particular group of nurses, each committee is now concerned with all nurses on a given subject. Thereby stress is placed upon those things which unite rather than upon those which divide.

A glance at the program indicates how the five standing committees — Constitution and Bylaws, Finance, Nursing Education, Nursing Service, Publicity and Public Relations — propose to report their respective activities. In addition the chairman of each will reveal whether or not the new structure has facilitated committee functions actively during the biennium. While our organization delegated a share of its authority to each committee it has not at any time relinquished control over the matters referred. Only by your approval of these reports and recommendations is committee action adopted as the decision of the Association as a whole.

According to our bylaws,

The President shall preside at all general and special meetings of the Executive Committee. She shall be, ex-officio, a member of all committees excepting the Nominating Committee. She shall perform all acts and deeds pertaining to her office and shall exercise a general control and supervision over the affairs of the Association.

I assure you that the foregoing responsibilities have been discharged to the best of my ability. Several instances combined to make my term of office a rewarding experience.

When the Association approved of new machinery it directed that it should be set up in new quarters. One of the first duties of the head of the household was house-hunting — an interesting experience indeed. With a leaning toward traditional architecture, we learned with regret that the commodious quarters of a lovely house surrounded by a garden and well-kept lawns, was withdrawn from the market just as the pen was poised above the dotted line. However, when the pen descended, it was to approve a lease on highly suitable quarters where freedom from snow-shovelling and grass-mowing may compensate for

contemporary architecture. True to form, the head of the household had no share in the task of sorting, packing, moving, unpacking and settling in Ottawa. On our arrival in December 1954, we became the 125th national organization to be at home in the Capitol city.

In assessing the advantages of the new location in terms of our objectives, we would mention the increased facility of communication with such national organizations as the Canadian Association of Social Workers, Canadian Welfare Council, Canadian Tuberculosis Association and the Victorian Order of Nurses for Canada. Such departments of the Federal Government as that of National Health and Welfare, Immigration, Labor and the Dominion Bureau of Statistics are also within easy access. On many occasions National Office has received requests for information from certain embassies, members of parliament and the editorial staff of the parliamentary press gallery. The Canadian Press has had a representative visit National Office and has indicated that its services are available on request.

The Biennial Meeting of the Board of Directors of the International Council of Nurses in Istanbul, Turkey, August 1955 provided an opportunity for the President and General Secretary to carry national thinking to the international level. Our association has representation on the Council of the Florence Nightingale International Foundation and on six of the standing committees of the International Council of Nurses. The President's account of the Board of Directors' meeting appeared in the January issue of *The Canadian Nurse*.

Of international importance is the recent announcement that a conference on "How to Plan Nursing Studies" is scheduled for November of this year in Sevres, France. The stated purpose of the conference is "to promote research, to find the best methods for research, and to give leadership to research." Miss Margaret Arnstein, Chief of the Division of Nursing Resources in the U.S. Public Health Service will serve as conference leader. Our association indicated a desire to participate and in the near future will select its representative.



In February, 1956, the Deputy Minister of National Health and Welfare invited the President and General Secretary of the Canadian Nurses' Association to meet the officials of that Department to review the proposed provisions regarding health insurance. This provided an opportunity for an informal and informative discussion as to what we as citizens and nurses may expect if and when such a program becomes effective.

In March, 1956 the President, the General Secretary and Miss Dorothy Percy constituted a delegation which presented a brief on behalf of the Canadian Nurses' Association to the Royal Commission on the Economic Future of Canada. Our submission outlined basic needs, present and future, and emphasized financial assistance for nursing education and research.

April 1956 saw representatives of the Canadian Medical, Canadian Hospital and Canadian Nurses' Associations conferring on topics of mutual interest. It permitted a sharing of viewpoints helpful to all.

Last month your President was invited to attend the 40th annual meeting of the American Nurses' Association. In addition to carrying greetings to that large and representative group — some 10,000 of whose members filled the arena on the opening night — your President considered it a privilege to be permitted to "sit in" on several stimulating sessions where problems

akin to ours, although affecting many more individuals were either resolved or referred for subsequent study. The convention atmosphere illustrated the wisdom of Florence Nightingale's statement that professions like nations can only flourish through an individual sense of corporate responsibility. The President has participated also in meetings of the Canadian Hospital Council, the Victorian Order of Nurses for Canada, the National Council of Women of Canada, the Ontario Hospital Association and the Registered Nurses' Association of Ontario.

We recognize that the progress of our association has to a great extent been made possible by the work of our headquarters staff. Their contribution which we acknowledge with sincere appreciation has been of a high order both individually and collectively. In closing I wish to express my appreciation and that of the Executive Committee for the cooperation of all members of the Canadian Nurses' Association in carrying on our work through the past biennium and to thank you for the privilege of serving as your representative. If tomorrow's pattern is to reflect our theme, nursing progress demands constant challenge, bold thinking, critical study, pointed discussion and trial in the practice of new ideas.

GLADYS J. SHARPE,  
*President,*  
*Canadian Nurses' Association*

In general, halitosis should be considered as a symptom and not as a disease. The most frequent cause is related to the teeth. Faulty oral hygiene permits food debris to collect between and about the teeth and favors decomposition by oral bacteria. Food particles stagnate between the teeth and at the gum margins unless they are eliminated by brushing and the use of dental floss after each meal. Meat fibres can become foul within a matter of hours when not removed. The decay of decomposing food particles produces a distinctly unpleasant odor, as do unclean and improperly kept dentures. Cavities in the teeth should be filled and tartar removed periodically. When pockets of pus form along the gum margins, considerable destruction of tissue and coexistent halitosis ensue unless this condition is

treated. Pyorrhea is a common cause of bad breath; here, the gums become inflamed, and small pus pockets surrounding infected teeth cause the latter to loosen.

To complicate matters, halitosis has a number of other causes. For one, bad breath is traceable to disorders of the nose, the sinuses and the tonsils. Stagnant accumulation of infected material in these regions is likely to produce a disagreeable odor. Disorders of the lungs also lead to halitosis, and this is equally true of chronic disturbances of the stomach, intestines and the liver. In such instances, it is believed the foul gases produced in the intestinal tract are absorbed into the blood, excreted into the air in the lungs, and later exhaled. Excessive smoking is still another offender.

— N. D. FABRICANT, M.D.

# Summary of Clinical Laboratory Procedures

M. M. WATSON, M.D., F.R.C.P. (C)

PROBABLY EVERYONE associated with the activities of a large, modern, general hospital will be impressed, if not confused, by the high innumerable tests that are performed on the patients. In this connection, the rest of the nursing staff in laboratory investigations should not be limited to mere formalities, such as the filling out of requisition forms, directing the technician to the proper patient and the collection and labelling of specimens. While these functions constitute important responsibilities of the nurse in addition to the proper conduct of laboratory tests, doubtless she will exert a more intelligent interest in her duties and have a better understanding of the patient if she possesses some knowledge of the procedures that are carried out. With a view to supplying relevant information in a condensed form, the following tables are presented.

## TESTS IDENTIFIED WITH PROPER NAMES

Frequently laboratory tests are ordered by giving only a man's name, even although the terms might apply equally well. Technical and analytical procedures often are known best by the names of the men who discovered them or were associated with their development and popularization. Below are those most commonly encountered.

*Addis count* — a quantitative estimation of red cells and casts in urine sediment.

*Ascheim-Zondek* — a test for pregnancy.

*Bence-Jones protein* — a peculiar type of protein found in the urine of patients with multiple myeloma and certain other diseases.

*Bodansky unit* — the amount of phosphatase required to liberate 1 mg. of phosphorus.

*Coombs* — a test used in pregnant women and newborn infants relative to Rh sensitization; also in hemolytic anemias.

*Exton-Rose* — a sugar tolerance test for detection of diabetes.

*Fantus* — an estimation of chlorides in urine.

*Fishberg* (concentration or dilution test) — kidney function tests to evaluate the kidney's ability to concentrate or dilute urine.

*Frei* — a skin test for a venereal disease, lymphopathia venereum.

*Freidman* — a test for pregnancy.

*Hanger* — cephalin-cholesterol flocculation test.

*Hinton* — a test for syphilis.

*Kahn* — a test for syphilis.

*Kepler* or *Kepler-Power* — procedures for the diagnosis of Addison's disease.

*King-Armstrong unit* — the amount of phosphatase required to liberate 1 mg. of phenol.

*Kline* — a test for syphilis.

*Kolmer* — a test for syphilis.

*Lange's Colloidal Gold* — performed on the C.S.F. as an aid in diagnosis.

*Lee and White* — a test of blood coagulation time, using venous blood.

*MacLagan* — thymol turbidity and flocculation.

*Mosenthal* — a two-hour specific gravity volume test for evaluating kidney function.

*Papanicolaou* — a technique for the identification of cancer cells.

*Quick* — a technique for estimating prothrombin; (refers to a man's name not speed of performance).

*Paul-Bunnell* — a serological test for infectious mononucleosis.

*Rowntree* — P.S.P. test of kidney function.

*Rumpel-Leede* — not a laboratory test but a method for determining capillary fragility by inflating a blood pressure cuff and counting the petechiae in a circumscribed area of skin.

*Schilling* — a special differential W.B.C. to determine the ratio of young to mature neutrophils.

*Somogyi* — often referred to in relation to serum amylase.

*Sulkowitch* — a test for calcium in urine.

*Van den Bergh* — a test of liver function.

*Wallace and Diamond* — a method for estimating urobilinogen in urine.

*Wassermann* — the original test for syphilis.

*Watson* — urobilinogen in urine and feces.

*Westergren* — a technique for performing the sedimentation test.

*Widal* — a serological test for typhoid and paratyphoid fevers.

*Wintrobe* — a special tube for determining red cell volume and sedimentation rate.

*Wohlgemuth* — referred to in relation to serum amylase.



*Ziehl-Neelsen* — a stain for acid fast bacteria, usually for tubercle bacilli.

## A GLOSSARY OF ABBREVIATIONS AND SYMBOLS

This is the era of the abbreviated form of expression. Often one is bewildered by the numerous combinations of letters referring to certain organizations or establishments. A growing list of abbreviations has entered into medical parlance. Abbreviations are frequently employed when requesting or referring to many laboratory procedures. Below are the most commonly used abbreviations and symbols with brief descriptions of their meanings.

**Ac.** — acid.

**A:G ratio** — a figure obtained by dividing the value for the plasma or serum albumin by that for the globulin.

**Alk.** — alkaline.

**A-Z. test** — Asheim-Zondek, a test for pregnancy.

**A.F.B.** — acid-fast bacillus; a characteristic staining quality of the tubercle bacillus.

**B.M.R.** — basal metabolic rate.

**B.S.** — blood sugar.

**B.S.P.** — bromsulphalein; a liver function test.

**B.T.** — bleeding time.

**B.U.N.** — blood urea nitrogen.

**C.B.C.** — complete blood count; usually implying hb., r.b.c., w.b.c., diff. and appearance of the red cells.

**cc.** — cubic centimeter.

**C.C.F.** — cephalin cholesterol flocculation test.

**CO<sub>2</sub> C.P.** — carbon dioxide combining power of blood plasma.

**Creat.** — creatinine; a constituent of blood and urine.

**C.S.F.** — cerebrospinal fluid.

**C.V.I.** — cell volume index.

**- Diff.** — differential; used with reference to a smear of blood or C.S.F. to determine the types and percentages of the white blood cells present.

**ECG or EKG** — electrocardiogram.

**Eos.** — eosinophile; a variety of white blood cell.

**E.S.R.** — erythrocyte sedimentation rate; sedimentation test.

**F.B.S.** — fasting blood sugar.

**F.S.H.** — follicle stimulating hormone.

**g. or gm.** — gram.

**µg** — microgram.

**G.A.** — gastric analysis.

**G.C.** — gonococcus; the causative organism of gonorrhea.

*Greek letters:*

**α** — alpha

**β** — beta

**γ** — gamma

**μ** — mu

**Hb. or Hgb.** — hemoglobin.

**H. & E.** — hematoxylin and eosin stain used in the preparation of pathological material for examination.

**Ht.** — hematocrit.

**I.I.** — icteric index; a chemical test on serum to reveal the degree of jaundice.

**I.M.** — infectious mononucleosis.

**O.T.** — old tuberculin; a skin test for tuberculosis.

**17-KS.** — 17-ketosteroids; a hormone assay on urine to study adrenal or other glandular disorders.

**L. or l.** — liter.

**L.E.** — lupus erythematosus.

**Lymph.** — lymphocyte; a variety of white blood cell.

**ml.** — milliliter; 1/1000 part of a liter; approximately the same as cc. but a more exact expression of measurement.

**M.C.H.** — mean corpuscular hemoglobin.

**M.C.H.C.** — mean corpuscular hemoglobin concentration.

**M.C.V.** — mean corpuscular volume.

**meq.** — milliequivalent.

**meq./l** — milliequivalents per liter.

**Mg. or mgm.** — milligram.

**Myelo.** — myelocyte; the forerunner of the granular leukocytes.

**Neut.** — neutrophiles; a variety of white blood cell.

**N.P.N.** — non-protein nitrogen.

**Pap. Stain** — Papanicolaou stain for cancer cells.

**P.B.I.** — protein-bound iodine; an estimation used in connection with thyroid function.

**pH.** — a symbol used to express acidity or alkalinity.

**Pl. Ct.** — blood platelet count.

**P.S.P.** — phenolsulphonphthalein test; method for assessing kidney function.

**R.B.C.** — red blood cell count.

**Rh** — Rhesus; the Rh factor.

**Retic.** — reticulocyte.

**S.I.** — saturation index; a test used in hematology.

**T.B.** — tuberculosis.

**T.P.I.** — Treponema pallidum immobilization; a specific test of serum for syphilis.

**U.A.** — urine analysis.

**Ur. Ac.** — uric acid.

**W.B.C.** — white blood cell count.

**W.R.** — Wasserman reaction.



# HEMATOLOGICAL VALUES

<i>Determination</i>	<i>Normal Values</i>	<i>Clinical Significance</i>
Hemoglobin	Adult males— 90 to 115% (av. 100) 14 to 18 gm. (av. 16) Adult females— 80 to 100% (av. 90) 12 to 16 gm. (av. 14) Infants—(1 day to 2 wk.) 100 to 160% (av. 120) 15 to 25 gm. (av. 20) Children—(6 mo. to 2 yr.) 65 to 100% (av. 80) 9 to 15 gm. (av. 12)	Decreased in the anemias. Increased in polycythemia and hemoconcentration (shock, burns, heart failure).  Decreased in hemolytic disease of the newborn (erythroblastosis).
Red blood cells (erythrocytes)	Adult males—5 to 6 millions per cu. mm. Adult females—4.5 to 5.5 millions per cu. mm. Infants—about 7 millions per cu. mm. at birth; gradual drop to adult figure at 15th year.	Decreased in the anemias. Increased in polycythemia and hemoconcentration (shock, burns, heart failure).
Hematocrit index	0.85 to 1.0	Low in iron-deficiency and hemorrhagic anemias; high in pernicious anemia.
Cell volume (hematocrit) (volume of packed red cells)	Males 42-50% Females 40-48%	Reduced in the anemias. Increased in polycythemia.
Volume index	0.85 to 1.15	Decreased in iron-deficiency anemia. Increased in pernicious anemia.
White blood cells (leukocytes)	5,000 to 10,000 per cu. mm.	Increased in many infectious and inflammatory conditions and in the leukemias. Decreased in agranulocytosis, aplastic anemia and aleukemic leukemia.
Differential white cell count	Neutrophils 55-70% Mature forms 52-65% Young forms 3-5% Lymphocytes 20-30% (up to 50% in children) Monocytes 3-10% Eosinophiles 2-4% Basophiles 0.5-1% Myelocytes 0 Myeloblasts 0	Increased in many infections. Decreased in agranulocytosis.  Increased in lymphatic leukemia, infectious mononucleosis and whooping cough.  Increased in many allergic conditions. Present in myelogenous leukemia.
Neutrophils (total)	100-400 per cu. mm.	Often high in allergies and Hodgkin's disease; diminished after ACTH with normally functioning adrenals.
Prothrombinogen	200-400 mg.% Fibrinogen 10-60 seconds	Decreased or prolonged in severe liver disease and in a complication of pregnancy.
Mean corpuscular hemoglobin	27-32 micromicrograms	Increased in macrocytic anemias (e.g. pernicious anemia); low in hypochromic anemias.
Mean corpuscular volume	80-94 cu. microns	Same as above.

<i>Determination</i>	<i>Normal Values</i>	<i>Clinical Significance</i>
Mean corpuscular hemoglobin concentration	33-38%	Increased in macrocytic anemias (e.g. pernicious anemia); low in hypochromic anemias.
Peroxidase reaction	Lymphocytes have no granules; monocytes have a few and cells originating in the bone marrow (e.g. neutrophils and myelocytes) have many.	Useful in distinguishing acute lymphocytic leukemia from acute myelogenous leukemia.
Reticulocytes	0.5 to 1.5% of all red blood cells.	Increased in p.a. following liver disease (temporary) and in hemolytic anemias (persistent).
Red cell fragility (blood fragility test)	Hemolysis begins at 0.44 to 0.42% NaCl. Hemolysis complete at 0.34 to 0.30% NaCl.	Fragility increased in hemolytic jaundice; decreased in obstructive jaundice.
Saturation index	0.9 to 1.1	Increased in macrocytic anemias (e.g. pernicious anemia); low in hypochromic anemias.
Sedimentation rate (Westergren method)	Men—1 to 10 mm. in 1 hour. Women—1 to 15 mm. in 1 hour.	Increased in infections and inflammatory conditions and in many organic diseases.
Blood platelets (thrombocytes)	200,000 to 400,000 per cu. mm.	Low in thrombocytopenic purpura and leukemia.
Bleeding time	1 to 3 minutes.	Prolonged when platelets reduced (e.g. thrombocytopenic purpura).
Coagulation (clotting) time	5 to 10 minutes (test tube method). 1 to 5 minutes (capillary tube method).	Prolonged in hemophilia; also after heparin administration.
Clot retraction test	Complete and perfect in 24 hours.	Delayed and imperfect in thrombocytopenic purpura (deficient platelets).
Prothrombin time	Prothrombin clotting time—15 to 30 seconds. Prothrombin—85 to 100%.	Prothrombin clotting time increased in liver disease; percentage decreased after dicumarol administration and in obstructive jaundice.
Blood group (types)	O 45% of individuals A 40% of individuals B 10% of individuals AB 5% of individuals Rh positive 85% of individuals Rh negative 15% of individuals	Essential to determine before transfusion.  Important in pregnancy and certain conditions involving the newborn; also in patients receiving repeated transfusions.

### BLOOD, PLASMA OR SERUM CHEMISTRY VALUES

<i>Determination</i>	<i>Normal Values</i>	<i>Blood Specimen Required</i>	<i>Minimal quantity of blood required (cc. or ml.)</i>	<i>Note</i>	<i>Clinical Significance</i>
Amino Acid N	5-8 mg.%	oxalated	10		Increased in liver disease and eclampsia.

<i>Termination</i>	<i>Normal Values</i>	<i>Blood Specimen Required</i>	<i>Minimal quantity of blood required (cc. or ml.)</i>	<i>Note</i>	<i>Clinical Significance</i>
Phosphatase	12-17 Wohlgemuth units; 80-150 Somogyi units.	clotted	10	Do not draw during or just following intravenous glucose or after administration of morphine.	Increased in acute pancreatitis.
Ascorbic Acid (amin C)	0.6-1.2 mg. %	oxalated	5	Blood must be placed in a tube surrounded by ice and sent immediately to the laboratory.	Low in scurvy.
Bicarbonate	26-30 meq./l.	Heparinized or oxalated	5	Draw in special syringe without stasis from tourniquet.	Reduced in acidosis. Increased in alkalosis.
Bilirubin (an den grgh test)	0.1-0.5 mg.%	Clotted	10		Increased in jaundice; latent jaundice 0.5 to 2.0; clinical jaundice above 2.0.
Bromide	0 - 1.5 mg.%	Clotted or oxalated	10		Important in the diagnosis of bromide poisoning.
Calcium	9-11 mg.% 4.5 - 5.7 meq./l.	Clotted	10	Syringe and tube must be specially prepared to avoid error from calcium in tap water.	Low in hypoparathyroidism and sprue (tetany); increased in hyperparathyroidism and some bone conditions.
Carbon dioxide combining	55 - 75 vol.%	Heparinized or oxalated	5		See bicarbonate above.
Chlorides	96-105 meq./l.	Clotted	5		Reduced by vomiting, starvation and after gastrointestinal surgery.
Cholesterol (sterol al ers e)	140-250 mg.% 80-200 mg.% 50-60 mg.%	Clotted or oxalated	10	Total cholesterol and cholesterol esters done on same sample.	Increased in hypothyroidism, diabetes and nephrosis.
Creatinine	1-2 mg.%	Oxalated	5		Increased in severe nephritis.
Glucose (se sting)	80-120 mg.%	Oxalated	5	Up to 160 after meals.	Increased in diabetes mellitus; decreased in hyperinsulinism.
Iodine (protein- )	5-10 micrograms %	Clotted	12	Strictly avoid any contact with iodine.	Increased in hyperthyroidism.
Urea (total)	385 - 675 mg.%	Oxalated	10		Altered in various diseases.
Amylase	0-2 units	Clotted	10		Increased in acute pancreatitis.



<i>Determination</i>	<i>Normal Values</i>	<i>Blood Specimen Required</i>	<i>Minimal quantity of blood required (cc. or ml.)</i>	<i>Note</i>	<i>Clinical Significance</i>
Magnesium	1.8 - 3.6 mg. %	Clotted	10		Changed in various unrelated diseases.
Non-protein Nitrogen	25-35 mg. %	Oxalated	10		Increased in nephritis, uremia and intestinal obstruction; increased in pregnancy.
pH (reaction)	7.35-7.45	Heparinized	5	Drawn in a special syringe without stasis.	Diminished in uncompensated acidosis; raised in uncompensated alkalosis.
Phosphatase acid	1.5 Bodansky units 3.0 King-Armstrong units.	Clotted	5		Increased in cases of cancer of the prostate with metastases to bone.
Phosphatase alkaline.	Bodansky Units Adults—1.5-4. Children—5-12. King-Armstrong units Adults 5-15 Children 10-20	Clotted	5		Increased in certain disorders of bone and in biliary obstruction.
Phosphorus (inorganic)	Adults—2-4 mg. % Children—4-6 mg. %	Clotted	5		Increased in severe nephritis; in some cases of rickets; decreased in conditions in which serum calcium is elevated.
Phospholipids	110-250 mg. %	Oxalated	5		Important in relation to disorders involving fat metabolism.
Potassium	3.5 - 5.0 meq./l.	Clotted	10	Serum must be separated from the cells within 1 hour.	Increased in renal failure; severe Addison's disease; increased in diabetic coma.
Protein Total Albumin Globulin A : G ratio	6.0-8.0 g. per 100 cc. 4.5-5.0 g. per 100 cc. 1.5-3.0 g. per 100 cc. 1.5 to 2.5 : 1	Oxalated or clotted	10		Decreased as a result of malnutrition and prolonged albuminuria (nephrosis), liver disease and starvation, causing edema; increased in certain conditions associated with hyperproteinemia.
Sodium	136 - 145 meq./l.	Clotted	5		Diminished by vomiting, gastric intestinal disorders, tube drainage (postoperative), diabetic coma, Addison's disease; increased after injudicious use of NaCl solutions in patients with impaired kidney function.
Sugar (glucose)	80-120 mg. %	Oxalated	5	See glucose above	

<i>Examination</i>	<i>Normal Values</i>	<i>Blood Specimen Required</i>	<i>Minimal quantity of blood required (cc. or ml.)</i>	<i>Note</i>	<i>Clinical Significance</i>
	25-40 mg. %	Oxalated	8		Increased in nephritis; decreased in pregnancy.
Urea Nitrogen	10-15 mg. %	Oxalated	8		Same as urea.
Uric acid	3-5.5 mg. %	Clotted	10		Increased in acute gout, in nephritis and leukemia.
Creatinin A	18-60 $\mu$ g.	Clotted or oxalated	10		Subnormal due to deficient diet.

### KIDNEY FUNCTION TESTS

<i>Tests</i>	<i>Principles</i>	<i>Normal Values</i>
Specific gravity test (Shoberg)	Based upon the specific gravity of 3 specimens of urine voided at hourly intervals in the a.m. after fluid restriction.	Specific gravity of at least one specimen should be at 1.025 or higher.
Urea ion test (Shoberg)	Primarily a measure of the blood supply of the kidneys.	First hour specimen about 400 cc. with specific gravity 1.001 to 1.003. Thereafter, less volume and higher sp. gr. with about 100 cc. at 1.012 to 1.016 at the 4th hour.
Urea nthal (2-hour specific gravity-volume test)	Based chiefly upon variations in specific gravity of 2-hour specimens during the day and volume and sp. gr. of night urine.	The difference between the highest and lowest sp. gr. not less than 9 points. The highest sp. gr. for the 2-hr. day specimens will be 1.018 or more. The night urine is 250 to 400 cc. with a sp. gr. of 1.018 or above.
Disodium phenylmercuriolsulphonphthalein	The dye is eliminated by glomerular filtration and tubular excretion.	Both kidneys: 40 to 60% in 1st hour; 20 to 25% in 2nd hour (total 60 to 85%). Fractional method — 25% or more in 1st 15 minutes. Kidneys separately: first appears in 3 to 5 minutes after intravenous injection.
Urea clearance	The excretory function of the kidney with special reference to urea is measured by a comparison of the concentration of this substance in the blood with that in the urine.	The average normal adult excretes the amount of urea contained in 60 to 95 cc. of blood per minute (average 75 cc.).
Urea Concentration Test	A test of the ability of the kidney to concentrate the constituents of the urine with particular reference to urea.	Urea attains a concentration of 2% or more in at least one specimen, providing the volume of urine does not exceed 120 cc. in the 1st hour or 100 cc. in the 2nd and 3rd hours.

### URINE VALUES

<i>Examination</i>	<i>Normal Value</i>	<i>Specimen Required</i>	<i>Note</i>	<i>Clinical Significance</i>
Urea Nitrogen	0.5 - 1.0 g.	24 hr.		Increased in some liver and metabolic diseases.

<i>Determination</i>	<i>Normal Values</i>	<i>Specimen Required</i>	<i>Note</i>	<i>Clinical Significance</i>
Calcium	Under 150 mg.	24 hr.	Patient must be on special diet.	Increased in hyperparathyroidism.
Chlorides	5 g. per liter	random		Important in controlling saline administration.
Creatine	Under 100 mg.	24 hr.	Preserve with toluol.	Used in the study of muscle diseases.
Creatinine	Males 1.5 - 2 g. Females 0.8 - 1.5 g.	24 hr.	Preserve with toluol.	Normally excretion constant; altered in certain metabolic disorders.
Diastase	16 - 30 units	Random	Urine must be fresh.	Greatly increased in acute pancreatitis.
Follicle - stimulating hormone (FSH)	Before puberty, less than 6.5 mouse units per 24 hr.; after puberty, 6.5 - 52 mouse units per 24 hr.; after menopause, 96 - 600 mouse units per 24 hr.	24 hr.		Important in the investigation of endocrine disturbances.
17-Ketosteroids	Under 8 years 0.2 mg. Adolescents 2-20 mg. Males 8-20 mg. Females 5-14 mg.	24 hr.		Important in the investigation of endocrine disturbances.
11 - oxy - ketosteroids	0.06-0.2 mg. per 24 hr., per sq.m. of body surface (adults, 0.1-0.4 mg. per 24 hr.).	24 hr.		Important in the investigation of endocrine disturbances.
Urobilinogen	Up to 1:20 dilution	Random or 24 hour	Preserve with sod. carb. under petroleum ether.	Increased in liver disease and hemolytic jaundice.

### LIVER FUNCTION TESTS

<i>Tests</i>	<i>Principles</i>	<i>Normal Values</i>	<i>Note</i>
Bromsulphalein Test	Bromsulphalein after intravenous injection is excreted almost entirely by the liver.	$\frac{3}{4}$ hr. after the intravenous injection of 5 mg. per kg. not more than 5% of the dye remains in the plasma.	Used in patients without jaundice.
Cephalin-cholesterol flocculation test	This test depends upon the capacity of the blood serum in cases of parenchymal liver disease to flocculate a suspension of cephalin-cholesterol emulsion.	0 to ++ in 48 hours.	Can be used in patients with jaundice.
Galactose Tolerance	The liver is the only organ which can convert galactose to glycogen and store it.	Normally not more than 3 gm. of galactose are excreted in the urine during a 5-hr. period following the ingestion of 40 gm. of galactose.	Same as above.



<i>Tests</i>	<i>Principles</i>	<i>Normal Values</i>	<i>Note</i>
chol- eculaculion	The alteration in the plasma proteins in parenchymal liver disease causes precipitation of a solution of thymol.	0 to + in 24 hours.	Can be used in patients with jaundice.
chol- idity	Same as above	0 to 4 units.	More valuable in the diagnosis of acute than of chronic liver disease.
Hippuric Acid Metabolism	Based upon the capacity of the liver to conjugate glycine and benzoic acid into hippuric acid with elimination of this substance in the urine.	In the oral test the excretion of 3.0 to 3.5 gm. in the 4-hr. urine. In the intravenous test the excretion of 0.7 gm. in the 1-hr. urine.	
Urobilinogen	Normally the liver re-excretes the urobilinogen absorbed from the bowel.	1:20 dilution of the urine.	

### INVESTIGATIONS OF CARBOHYDRATE METABOLISM

<i>Tests</i>	<i>Principles</i>	<i>Normal Values</i>
Standard 1-dose 2-Sugar Tolerance Test	A test of the ability of the body to store and utilize ingested dextrose.	The fasting blood sugar is normal. After the ingestion of a specified amount of dextrose the blood sugar returns to normal within 2 hours. The maximum blood sugar should not exceed 180. No glycosuria.
1-dose 1-hour on-Rose tol- erance test)	Based on the principle that the more sugar that is given to a normal person, the more is utilized.	Blood sugar level of the 60 min. sample is less than, equal to, or does not exceed the 30 min. sample by more than 10 mg.%. No glycosuria.
Intravenous Sugar Tolerance Test	Obviates the possibility of impaired absorption from the intestine.	Blood sugar reaches the normal fasting level within 1 to 1½ hr.
Insulin Sensitivity	A test of the activity of insulin to promote the withdrawal of glucose from the bloodstream following ¼ unit of regular insulin per kilo. body weight.	Blood sugar falls about 45 mg.% lower 1 hr. after ingestion of dextrose with insulin than with dextrose alone.

### TESTS OF THE CEREBROSPINAL FLUID

<i>Tests</i>	<i>Normal Values</i>	<i>Clinical Significance</i>
Appearance	Clear and colorless (like water). May be slightly blood tinged from needle trauma. No clot.	Cloudy, turbid or grossly purulent in meningitis. Bloody or yellow when hemorrhage involves central nervous system.
Pressure	Adult 100 to 200 mm. water (patient lying down). 200 to 300 mm. water (patient sitting). Child 50 to 100 mm. water (patient lying down).	Increased in meningitis, edema of the brain, hemorrhage, neurosyphilis. Decreased in shock, dehydration and spinal canal block.

<i>Tests</i>	<i>Normal Values</i>	<i>Clinical Significance</i>
Cell Count	1 to 5 per cu. mm. (lymphocytes).	Increased in the various types of meningitis, poliomyelitis, neurosyphilis and encephalitis. Pus cells predominate in the acute bacterial processes. Lymphocytes are found in tuberculous meningitis, poliomyelitis, and neurosyphilis.
Colloidal Gold Test	0000000000	5554321000 Paretic type curve. 0244310000 Luetic or tabetic type curve. 0000245520 Meningitic type curve.
Protein	15 to 45 mg. per 100 cc.	Increased in those conditions with an increased count (see above). Increased also in spinal cord tumor, caries of the spine and in infectious polyneuritis.
Sugar	45 to 70 mg. per 100 cc.	Increased in diabetes, epidemic encephalitis, uremia and sometimes in brain tumor. Decreased in acute meningitis, tuberculous meningitis and insulin shock. Normal values generally found in neurosyphilis.
Chlorides	Adult 720 to 750 mg. per 100 cc. Child 625 to 760 mg. per 100 cc.	Definitely low in tuberculous meningitis; high values may be found in uremia.

### SOME MISCELLANEOUS PROCEDURES

<i>Tests</i>	<i>Normal Values</i>	<i>Clinical Significance</i>
Gastric analysis Free HCl	Fasting — 5 to 20 degrees. After test meal (without histamine) — 25 to 50 degrees.	High when gastric or duodenal ulcer present. Low or absent with gastric carcinoma. Always absent in pernicious anemia after histamine.
Total Acidity	Fasting — 15 to 45 degrees. After test meal (without histamine) — 40 to 65 degrees.	
Urobilinogen in feces	Normally present	Increased in hemolytic jaundice. Decreased or absent in obstructive jaundice.
Congo Red Test	Less than 40% of the congo red disappears 1 hr. after its intravenous injection.	This is a test for amyloidosis and when the dye is present more than the normal amount the dye disappears from the blood.
Paul-Bunnell Test	Agglutination of sheep corpuscles in dilutions of serum up to 1:16.	This is a test for infectious mononucleosis in which condition agglutination occurs in high dilutions.
Basal Metabolic Rate (B.M.R.)	+ 15% to — 10%	High in hyperthyroidism (toxic goitre, thyrotoxicosis) and leukemia. Low in hypothyroidism (myxedema, cretinism).
Ascheim-Zondek and Friedman Tests	These tests are useful in differentiating cessation of menses due to disease, pregnancy and pregnancy; also in differentiating an enlargement of the uterus (fibroid) and pregnancy. Hydatiform mole and chorion-epithelioma give positive results. As a test for pregnancy it is about 98% accurate.	

The man who used to think nothing of working twelve hours a day now has a grandson who doesn't think much of it either.

# What it Means to be Old

ELISABETH C. PHILLIPS, B.S., M.A.

MARY HEATON VORCE was a woman of 64 when she asked for and got a job as war correspondent during World War II. She was well over 70 when she came back "home." One of her prize remarks at that time was, "Young folk may as well realize that they had better stop treating elderly people like me as if we were a nine-day wonder." Although a 70-year-old war correspondent may be a nine-day wonder, surely an elderly person no longer is, for old people make up a large part of our society today and their numbers are growing rapidly — more rapidly than any other portion of our population. Moreover, the old person of today is not the Whistler's Mother type for they seldom sit placidly and reflectively in a rocking chair.

This increased age of the population has come about pretty much in our own life time. For instance, when I was born *less than four per cent* of the population in the United States were people who had lived 65 years or more. Fifty years later *eight per cent* of the total was made up of our "older citizens." When I am 65 years old, I will be one of the *fifteen per cent* who will be that old or older. (The figures for Canada run about half of one per cent less than for the United States.)

Or let us look at it this way. When I was born my grandmother, then 68, was one of three million people who were over 65. When I was 50 my father, then 80, was one of 12 million over 65. When I am 65, I will be one of 18 million who will be in that so-called "old age" group. In other words, 15 years from now, one out of every 10 of the population in my country will be over 65. In Canada today it is one out of every 12 and in Nova

Scotia, it is one out of every 14. I, of course, will be among that rapidly growing group and so will be many of you. The fate of the rest of you will be even worse, for in the next 25 or 30 years, it is predicted that one out of every eight or nine will be over 65. Perhaps we had better resolve here and now, for a selfish reason if for no better, to do all that we can to help the younger generations learn good ways of caring for those who are older.

Tremendous public health advances are, of course, the reason for this increase in our older population. We can scarcely imagine how much the situation would be speeded up if a cure for cancer or a cure for heart disease, were found.

Two things are sure. People must learn to "grow old gracefully" and, second, their younger relatives must learn how to live with them, and let them live, far more happily than is usually the case today. I believe that we are beginning to see help on the horizon that will make it easier for us both to grow old ourselves, and, to live with those who are older than we are in a more successful manner. The day will come when even our grammar schools will keep these two needs in mind as they construct their curricula. Of course, much needs yet to be done for the surface is barely scratched.

We are concerned with the improvement of the nursing care of persons who are already advanced in years, especially those who have a long-term illness. First, we need to learn what the person who has lived through his mature years and who is entering into his old age is like, why he behaves as he does, and what his needs are — especially those needs that are outgrowths of age itself. His needs that are outgrowths of his illness are, of course, important also, but in this paper our attention is directed to his age needs alone. What then are the needs of the aged?

I expect if an older person felt free

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to express himself he might say — "First, I need to be treated as an individual — as a person. Because I am old, I am not very different from you." This desire to be thought of as an individual is an outgrowth of the very same ego-drives that make two-year old Johnny say — "I won't" or three-year old Sally scream and hit her head against a wall when she sees her mother's attention fixed on the new baby. It is the same ego-drive that engulfs a 22-year-old college student and makes him keep going until he is at the top of the dean's list. It is the same ego-drive that makes every one of us determine to make our mark in the world, no matter how many difficulties we must first overcome.

This, then, is what makes the old person kick up a row when his family fails to pay attention to him. By it he is really saying, "I am a person — not just your ancestor!" A few years ago a radio program in San Francisco had as its guest a Mrs. Martini who was 81. In the broadcast she declared a "bill of rights" for herself and for all other old men and women. It read thus:

- The right to be treated as a person.
- The right to be treated as a grown-up.
- The right to have a say about our own life.
- The right to a fair chance on our own merits.
- The right to a future.
- The right to have fun and companions.
- The right to be romantic.
- The right to the help of one's family in becoming interesting to that family.
- The right to professional help whenever necessary.
- The right to be old.\*

Other old people have worded their needs somewhat differently. Many times what they say expresses a fear, although that fear is not actually verbalized. For example, "We need good health" means, in fact, "We fear being helpless and dependent." Or they say, "We need enough money to live on." What they are actually telling us is, "We fear being dependent and

penniless. We fear being on the dole." They say, "We need to be let alone," but they mean, "We fear that we will have to take orders and agree to plans made *for*, and not *with* us." Others say something similar in still another way. "We need to live our own lives." Or they say, "We need to be ourselves. I've always liked to do so-and-so. Why should I stop now that I am older?"

Sometimes younger persons reply, "Old people expect too much of us," and then they turn deaf ears on what the older person is trying to tell them. Yes, young people say, "Old people expect too much of us," but isn't it rather that we, the younger people, expect too much of those who are older?

We expect *them* to do the adjusting, to tailor-make *their* lives to fit our own, and above all, we expect them not to make us feel guilty in the process!

The slowed reactions which are associated with the aging adult may be with or without apparent significance for the individual's particular social role. He has few appointments to keep so it will make little difference that his dressing or eating time is doubled. On the other hand, this slowing down of the reactions may make him much more liable to have accidents or to be unable to adjust to the demands of everyday life. Speed and timing are essential for survival under many circumstances and the speed factor seems to be intrinsic to many types of activities. Slowness of accomplishment is an irritating factor between us and the dawdling child, but between us and the slow-motion elderly patient, it may become a real barrier to our care.

We know that a characteristic of the aging process is that the rate of accomplishing anything is slower. Slowing down, whether it be physically or mentally, is one of the best indications that we have today that decline due to the aging process is occurring.

We feel hostile and annoyed when an old person refuses to stop smoking in bed, or to take his clothes off before going to sleep or to change his lifelong food habits. What we need is to understand that these behaviors are based on reasons, that this old person is not behaving thus, as did the Baby

\* A paraphrase of Dr. George Lawton's chapter from "Aging Successfully" published in its entirety, as "Bill of Rights for Old Age," in the *Journal of Gerontology*, January, 1947.

in Alice in Wonderland, merely to annoy.

I know how hard it is to accept all the behavior of older persons easily and happily. Those bits of food that are tucked away in a dresser drawer or in the bedside table, or even under the pillow, where they draw ants or flies and later on emit a most disagreeable odor; those piles of newspapers in the closet that are really a fire hazard and never will be used for any good purpose. Then there are those "tales" that are far from the truth. We hate to admit that some loved one is "lying" or that we cannot trust a patient not to pervert some incident and therefore get us into hot water.

It will be easier for us if we stop and think why this old person behaves as he does. Why does he hide the food, for instance? Can it be that he fears that he will be hungry and no food will be at hand? Can it be that he plans to eat it a little later and then honestly forgets that it has been kept? Why does he tell untruths? Is it that he didn't understand correctly in the first place, and really thinks that it was as he describes it? Or does his imagination run away with him and wishful thinking master truth, just as it does in childhood? Yes, all of these reasons are possible.

Now let us look at it in another way. Why are we so upset when an older person does something that is "childish" — when he dawdles over his meal or spills his food? If a child shows exactly the same behavior, we shrug it off. We say, "Oh, boys will be boys," or "You can't expect anything else from a child," but to the older person, we say — or at least we think — "For heaven's sakes, you should know better. I just can't take any more of that!"

The difference in our reaction lies in one very simple fact. We *expect* disobedience, unsocial or childish behavior from a child. It is what we call "*normal*" for him. But on the other hand, we don't expect this same kind of behavior from an aged person. Why don't we? It is just because we don't yet have the picture in our minds of what is "*normal*" behavior for an old person. We need to become more familiar with old age behavior patterns, and when we do, we will be able to accept those things that trouble

us now with a minimum of hostility and a maximum of understanding. When we have done this, we will find that the normal behaviors of the old and of the young are rather similar, and that they are both based on what — to them — seem to be good reasons.

Aging is now recognized as a period of life, just as distinct as is the growth of the preschool child or the development of the adolescent. For all practical purposes, it is that period which follows maturity. Aged people have similar characteristics, just as do children in the growth period. However, just as is the case with children, there are many individual variations in the pattern. We can speak of "*normal*" old age, but it is as difficult for us to do so, as it is to speak of "*normal*" adolescence because of this individualization. The fact that we cannot pinpoint the time at which the aging process begins, adds still further to our difficulty in trying to describe the "*normal*."

Another thing that we must keep in mind is that old age is not all decline and loss any more than all youth is growth and development. Generalizations are always dangerous, but there are four regarding the aging process in which we can truly put our faith:

1. There are wide individual differences in the rate of aging of cells, tissues, and organs of people even if those individuals have the same heredity and the same environment.

2. There are differences in the rate and amount of aging of cells, tissues and organs within the *same* individual. "A sixty-year old man can have a forty-year old heart, an eighty-year old liver, fifty-year old kidneys, and may be trying to live a thirty-year old life."\*

3. Old age does not necessarily beget a new personality. Rather it is as George Santayana has said: "People do not grow better or worse when they grow older; they remain the same, but later circumstances cause them to exhibit their character sometimes in a minor key with the soft pedal, so that they seem to us grown sweeter; and some-

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\* C. Ward Crampton, M.D. "What Geriatrics Means to the Medical Profession" *New York Medicine* — Vol. 3. No. 10, May, 1947.



times more harshly and disagreeably, when we think them sour and depraved." Old age acts as a "deinhibitor" and as age advances, the real characteristics of the individual are brought to the surface and exhibited.

4. Aging cannot be prevented. Regardless of all that is done by the individual or society, old age will come. But what we can do is to prevent *premature* aging.

The individual is called upon to make a series of adaptive changes throughout his life span. Old age is but the last of these adaptive changes. In old age, as in other periods of life, the ability of the individual to adapt is influenced by many things — what his relationships are and have been, what sort of adaptations he has already made and how he has made them and the way in which his life crises, such as puberty, marriage, parenthood, menopause, death of loved ones, have been met.

Normally old age is a period when an individual's inner resources decline, his external world narrows and the past seems to have more reality for him than the present. This is the pattern, but the speed with which this takes place varies with individuals. Illness is one of the factors which tend to speed up this decline. Perhaps it is because of nutritional limitations brought about by the illness, perhaps it is the strain to which the illness subjects the body and mind, or perhaps it is the fact that being ill shuts him away from the stimulation of his daily living. It may be any or all of these things. Also it may be due to the way in which he is treated while he is ill — treated as though he were a child rather than an adult by those giving him nursing care.

One of the things that it is important for us who are giving him care to remember is that in old age the future is uncertain, even frightening, while the present is full of frustrations. This is what makes it inevitable for him to think back and relive the "good old days," those days when he was in command of the situation and life constituted a challenge and not a fear. This denying of the present and future and embracing of the past, manifests itself in many ways:

Aged people frequently attach them-

selves to old things — the old chair, the old dress, the old shawl become precious and the fact that the chair covering is worn to ribbons, the dress dirty and the shawl full of holes, does not matter. It is not even recognized as a fact by the old person.

Aged people depend on a fixed routine of life for security, even as children do. If supper is not served on the dot, if the family decides to have two meals instead of three on Sunday, the old person is upset. The lateness with which the newsboy delivers the paper or the fact that he puts it on the side instead of the front porch becomes a major upsetting issue.

Aged people tend to reminisce about old friends and old accomplishments and to idealize those who peopled the past. Old ways of preparing food are the only ways. Old friends are the only true ones — the new is fearful.

Aged people have a different time sense. They forget what happened yesterday or even this morning, but can recall in detail matters that occurred 40 or 50 years ago.

Aged people tend to become obsessed with a single idea, no matter how absurd it seems to others, nor how many times it is denied by those who are younger. They tend to bring it into the conversation, over and over again, even though they know that it will once more be denied and that it may even make others cross.

Aged people tend to become untidy. Time is no longer so important to them and the fact that a garment has been worn steadily for a week is of no importance. Moreover, they may not be able to see the dirt or even smell the staleness of the garment. Often the effort to become clean is too much for them. The lack of muscular coordination means spilled food and to have a garment cleaned is an admission that this has happened, and that "old age" has arrived. Sometimes instead of this, the older person does the direct opposite and becomes obsessed with the desire to be clean and is excessive in his attentions of personal care. To be unquestionably clean is then the greatest aim in their lives, and no exceptions can be permitted. This, too, begets difficulties with those who deem themselves to be more "practical."

Aged people often are extremely obli-



vious to reality. This may make them unduly optimistic or pessimistic and may prevent them from making any practical plans for the future or even for today.

Aged people may exaggerate problems and show marked anxiety about trifling incidents. This tends to make them tell the untruths that are extremely hard for those about them to handle.

Aged people tend to hoard money, clothes, string, newspapers, anything that to them will assure security and independence.

The aging process is now being studied by many people in many ways. These studies extend from intensive personal analysis and self-rating to lengthy interviews between psychologists and older people, on to the laboratory where a whole gamut of biological studies is taking place, and thence into the field of psychiatry. The questions to which answers are being sought range from "What makes people age?" and "How can the aging process be slowed down?" to "How many foot candles of illumination should be provided for old people?" and "What types of door handles are easiest for old people to manipulate?"

As was pointed out before, many factors in the decline of older people resemble, in part, the growth factors of children; and decline, like growth, is neither uniform in all individuals nor for all processes and functions within a single individual. Quite apart from any pathological changes, decline is variable, both in its rate and character. We need to describe and plot these changes in a wide variety of structures and functions against time, or age, in order to catalogue what occurs during the aging process. This is exactly what has been done during the past 25 or more years in studying the growth of children. As yet we have no norm for measuring decline in the aging, as we now have for measuring growth in children.

Other studies will be needed to determine how much and what types of decline can take place before it reaches the crucial point and old age is recognized as having "arrived."

We also need facts concerning the effect of age on recovery from various types of illnesses, disabilities and other conditions, and in determining this nurses will have much to contribute.

Also, we should know more than we do now about the effects of age upon the learning and rehabilitation processes.

It has been said "energetic activity accompanied by deep concern delays deterioration for a measurable time." In other words when a person is vitally interested in life and is active in his living of it, his aging process is slowed. In the popular mind, the myth of retirement as the key to a happy life is oriented about the principle that absence of activity is both beneficial and preservative. Nothing could be further from the truth!

There are certain physical changes that occur in the aged about which we *do* have some facts. We know, for instance, that distinct neuroanatomical alterations are usually evidenced with advancing age; that both the weight and size of the brain diminish by several per cents as a person becomes aged; that the volume of cerebrospinal fluid is increased; that the dura mater is thickened and may contain deposits of calcium; that cell counts indicate loss of neurons accompanied by gliosis; and that there are many microscopic changes as well in the structure of the nervous system as age increases.

These things we do know but we do not yet understand how these changes effect the functioning of the body or the mind. There are other things that we now know about aging and their effects on the life of the individual. We know that the aged brain is more susceptible to insult by vascular insufficiency than is the younger brain; furthermore, we know that arteriosclerosis diminishes cerebral blood flow. This means that we should expect changes in both physical and mental behavior in the arteriosclerotic patient. These changes are "normal" for him.

One of the most important areas concerning the aged about which we have almost no real facts, is that of nursing care itself. This area is one with which we as nurses must be concerned. Further delay will be tragic for it is already late — too many people are now in need of our help.

It is easy for us to produce plausible reasons when we attempt to defend our abysmal neglect of this aspect of nursing care. Some of these reasons may

be sound, most are not. Whether they are or not, we can no longer use them as a crutch. We must become deeply concerned with the nursing of the aged — just as deeply concerned as we have been in the past with the nursing of infants and children and with the giving of good care to mothers before and after delivery. We must recognize that study and research in geriatric nursing is an important and long-neglected area. First we need to identify the basic knowledges in nursing and its many allied fields on which good care for the aged can be built. Then we must develop a body of skills and attitudes which will make it possible for nurses to put these knowledges to work as they care for older persons.

I do not advocate separation of geriatric nursing from the rest of nursing or in any way making it into a specialty. I would rather see geriatric nursing emphasized throughout all nursing curricula and all nursing service. It should not, of course, be allowed to be merely an after-thought and if it is integrated throughout the curriculum, there is a real danger that this may happen. Therefore, safeguards must be set up so that every phase of nursing will be related to the older person as well as to those of other ages and with other needs. There are certain obstacles to the better care of the aged that we should examine.

None of us wants to grow old and so we reject the idea that old age is an honorable estate.

Our attitude of fatalism suggests that the old have to die sometime.

There is a feeling that they have lived their lives and so should not try to mix into ours.

A fourth difficulty is our all-too-frequent attitude of surrender to the bigness of the problem and lack of willingness to try to find solutions.

It is generally agreed that postpartum psychosis is not a specific type of mental disease. Motherhood suddenly precipitates a predisposition to psychotic episodes in the patient. All such patients show one feature in common — hostility to the baby. The mother's inability to bear this hostility causes her to become psychotic. Formerly the mother was separated from the child and admitted to an observation ward or a

Another obstacle is our concern with the more dramatic needs of patients so that a diagnosis of "old age" does not have an appeal and we are, therefore, content to let someone else care for him.

Finally, the aged themselves resent being old. In the middle of the last century John Quincy Adams wrote this in his diary: "What can I, upon the verge of my 74th birthday, with a shaking hand, a darkening eye, a drowsy brain and with all my faculties dropping from me one by one, as the teeth are dropping from my head — what can I do for cause of God and man, for the progress of human emancipation . . . But yet my conscience presses me on; let me but die upon the breach."

The mature person has little difficulty in recalling many of the experiences that he had as an adolescent if he will but try to do so. Some mature persons remember what it was like to be a little child, tiptoe on the threshold of life and bubbling over with new experiences every hour. A very few persons believe that they remember parts of their own babyhood, and in one or two instances on record even into the birth hours themselves. But no one of us has ever been aged. We have no personal experience of what it is like. We need to listen and observe in order to learn. Above all, we need to turn our imagination loose and feed it with what facts we have until we develop a real understanding of what it is like to be old, albeit this understanding will be a vicarious one for many years to come. When we have developed that understanding may it permeate all of our contacts with the aged — whether those contacts be within our own homes or neighborhoods, with relatives or friends, or whether they result from the fact that we are nurses, concerned in seeing that the best of care is given our older citizens.

mental hospital. Recovery was common but relapses were more common. Now the baby is admitted with the mother and it is found that relapses occur much less frequently.

— COMMUNICATIONS ASSOCIATES, INC.

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Lots of times you have to pretend to join a parade in which you are not really interested in order to get where you're going.

— CHRISTOPHER MORLEY



# Diabetes Mellitus

MARY DERSCO

## NATURE OF THE DISEASE

**D**IABETES IS A DISTURBANCE of metabolism due to the total or partial inability of the tissues to burn carbohydrates. This inability is indicated by an excess amount of sugar in the blood and by the presence of sugar in the urine. The blood normally carries 100-120 mgm. of sugar per 100 cc. of blood and any additional sugar that is not burned overflows into the urine. Diabetes is due to the absence of sufficient insulin to enable sugar to be oxidized. In severe diabetes, the metabolism of protein, fat and sugar is affected.

## THE PANCREAS

The pancreas lies in the posterior abdomen behind the stomach. The head is enclosed in the loop of the duodenum and the tail is close to the spleen. This organ has an important role in the process of digestion. It produces an external secretion, the pancreatic juice, and an internal secretion, insulin. The former aids in the digestion of protein, fat and carbohydrates in the intestine. Insulin is the principal factor in the utilization of carbohydrates by the body cells. It is secreted by special cells of the pancreas which are arranged in clusters known as the Islands of Langerhans. Diabetes is due to the absence of sufficient insulin to enable sugar to be oxidized and can be corrected by the administration of this hormone.

## ETIOLOGY

Why the flow of insulin is diminished is not definitely known but there are many predisposing or associated factors. Among these are: worry, a sedentary life, bad food habits, obesity,

Miss Dersco graduated this year from Misericordia Hospital, Winnipeg. She was awarded the second Honorable Mention book prize in the Macmillan Award competition.

infection, disease of the gall bladder, nervous and emotional disturbance, diseases of other ductless glands, age, race, and heredity. While it has not been proved that diabetes is an inherited disease, it is often seen to occur in several members of the same family. It has been shown that when two diabetics marry, the children of this marriage are almost certain to have diabetes; but if a diabetic marries a non-diabetic half of the children are likely to have the disease. It also seems to afflict certain races. The Jewish people seem to have a greater number of diabetics in proportion to the population than other groups.

Diabetes is primarily a disease of the mature years as its greatest incidence is among persons between 50 and 60 years of age. However, it does affect people of all ages, even young children. The onset in children is usually acute, with loss of weight, strength, polyuria and glycosuria. In this age group the disease is always comparatively severe. Among adults, the onset often is so gradual that the disorder is not noticed for months or even years; in about 10 per cent of all patients its discovery is a surprise in routine urine examinations. Periodic medical examination, special precautionary measures in regard to overweight, treatment of infections and the early recognition of symptoms are advised, especially between the ages of 30 and 60.

## SIGNS AND SYMPTOMS

The symptoms which disturb the patient and send him to the doctor are:

Frequent and copious urination, known medically as polyuria;

Extreme thirst, known as polydipsia;

Dehydration, due to polyuria;

Excessive hunger, known as polyphagia;

Loss of strength;

Loss of weight;

Itchy skin.

When an analysis of the blood and urine of a patient with the foregoing



symptoms is made in all probability he will be found to show:

Sugar in the urine; increased sugar in the blood.

The patient may be sufficiently ill to require emergency treatment if he is in a state of ketosis (or acidosis) or perhaps even in coma.

## DIAGNOSTIC TESTS

Laboratory findings are the determining factors in the diagnosis of diabetes. The examination of the urine includes tests for: Volume, specific gravity, glucose, ketone bodies.

The normal *volume* excreted daily varies, of course, with the amount of fluids consumed and the amount lost through evaporation or perspiration. The normal limits, however, lie roughly between 1,200 cc. and 2,000 cc. for a 24-hour period. If sugar is present, the volume usually is increased; the total volume often exceeds 3,000 cc. in severe cases.

*Specific gravity* is the weight of a liquid as compared with an equal volume of water, usually 1 cc. of each. The weight of 1 cc. of water is 1 gram. The weight or specific gravity of normal urine averages from 1.008 to 1.030 gm. per cc. This additional weight depends on the amount of dissolved substances in the urine. The solids in solution are chiefly urea and salts; and in diseases of the kidneys, albumin. When the total solids of the blood exceed the normal concentration point, the body excretes a larger volume of urine which is followed by thirst and increased intake of fluids. When large quantities of sugar are excreted, the weight or specific gravity of the urine may be increased above 1.030. The total volume is also increased.

*Sugar in the urine*, except when found in mere traces, is strongly indicative of diabetes mellitus, although there are a few exceptions. These include renal glycosuria, when the renal threshold for glucose is lowered; alimentary glycosuria, when too much sugar has been ingested at one time for the liver to store the excess; pentosuria, when the body fails to oxidize a certain carbohydrate called pentose; fructosuria, when fructose is not utilized, and lactosuria in nursing mothers, when lactose is not used.

*Ketone bodies*: Certain substances may appear in the urine as the result of incomplete burning of the fats. The presence of these substances, known as ketone bodies, is indicative, of ketosis or diabetic acidosis which, if not corrected, may result in coma.

*Blood sugar test*: The presence of glucose in the urine is strongly suggestive of diabetes mellitus, but a blood sugar examination is necessary to make the diagnosis certain. This test is made after a 12-hour fast. In diabetes it will show much higher than the normal level of 100-120 mg. per 100 cc. of blood.

## REPORT OF A CASE

Mr. Mervin, a 70-year old white male, was admitted to hospital by ambulance on June 25. This was his third admission. He was in a slightly stuporous, disoriented and confused state. His admitting diagnosis was given as "diabetes with gangrene of the left foot."

*Social History*: A widower, and owner of his own business, Mr. Mervin seemed to be well fixed financially. His family consisted of one daughter and one son, both of whom were very devoted to their father — a man of high principles, very religious, of average intelligence and with good personal and hygienic habits.

*Medical History*: A diabetic since April, 1952, Mr. Mervin has been regulated on a diabetic diet with 15 units of PZI insulin daily. He had a right inguinal hernia last February. He had complained of cold feet during the winter though there was no throbbing or pain in his calves, no headache, dizziness or shortness of breath. He had a good appetite, good bowel habits and a good physical appearance; weight 190 lbs.

Mr. Mervin had had an abdominal sympathectomy in May. Three days later he developed inflammation on the medial side of the left great toe. It did not improve on hot fomentations and was amputated on June 3rd. The wound would not heal and amputation was advised of the leg to above the knee. The patient firmly refused to accept such a decision. His son consulted another physician and was told that there was a possibility that the infection could be controlled with conservative treatment.

**Physical Examination:** On admission, temperature was 99°, pulse 72, respirations 20; blood pressure 155/102. Examination revealed a well developed slightly obese man, who was both acutely and chronically ill. Examination of the left foot revealed that the great toe had been amputated with failure of the wound to heal. There was a profuse purulent discharge from the wound. The foot was badly infected.

**Laboratory findings:** Fasting blood sugar was 167 mg. per 100 cc. of blood. Specimen of urine showed a faint trace of albumin but no sugar.

**Culture of the discharge from toe stump** revealed the infective organism to be *Staphylococcus albus*.

**Drugs and Treatment:** For the treatment of diabetes, the physician ordered Protamine Zinc Insulin 10 units daily, with an 1800-calorie diabetic diet.

For the treatment of gangrene, Streptokinase and Varidase dressing alternately with Spectrocin ointment to be applied to toe stump. On July 13, in addition to the dressings the treatment was to include exposure of the raw area t.i.d. for half an hour, with dry dressing to be applied at bedtime.

Operative treatment consisted of split thickness graft from the thigh to the raw area of the toe after sloughed tissue was excised.

Following the operation, Bacitracin compresses were applied to the toe stump. Bacitracin is derived from the growth products of *Bacillus subtilis*. It is an antibiotic substance with a range of activity similar to penicillin, against gram positive cocci and spirochetes. Its action is principally bactericidal. Bacitracin is used topically for local infections.

This treatment seemed to be of marked value and the infection cleared up almost entirely excepting for a very small opening in the toe stump from which a purulent discharge persisted. The physician now ordered that the wound be irrigated with Bacitracin t.i.d. Using a canula and syringe, the Bacitracin was to be injected deeply into the opening of the wound. This treatment was carried out with the greatest care. The wound began to heal and closed over. The patient was discharged from hospital on November 21, in apparently good condition.

**Chronic complications:** Sometimes the complications first call attention to the fact that the patient has diabetes. There may be frequent attacks of boils and carbuncles, persistent eczema, or even gangrene; disturbances of vision (alternating near-sightedness and far-sightedness and cataract), pains in the extremities and loss of reflexes (peripheral neuritis, circulatory disturbances, arteriosclerosis; frequent infections, failure of wounds to heal; and coma.

**Acute Complications:** Acidosis results from incomplete oxidation of fats and the accumulation of fatty acids in the blood. If these acids are not removed, coma occurs. Coma can nearly always be prevented if the early symptoms are recognized and treatment is given promptly. The onset is frequently indefinite and sudden. Early symptoms are: loss of appetite, nausea, vomiting, abdominal pain, weakness, disturbance of vision, listlessness, and drowsiness. The tongue usually is dry and bright red, and the breath has the "fruity" acetone odor. Dyspnea in which the respirations are deep and labored (Kussmaul breathing), is one of the important signs. It is caused by stimulation of the respiratory centre by the fatty acids and is an attempt by the body to get rid of the excess carbon dioxide in order to lessen the acidity of the blood and keep its reaction normal. If untreated, drowsiness develops into complete unconsciousness and coma. The urine usually is decreased and on examination shows sugar, acetone and diacetic acid; albumin and casts are likely to be present also. The blood shows a decrease in carbon dioxide, an increase in sugar, and a marked leucocytosis.

The best treatment is prevention — avoid the conditions which predispose to, or deepen the coma. With the first symptoms of acidosis, the doctor should be notified and the patient should be put in bed and kept warm with blankets and hot water bags. He should be watched closely. Insulin, the amount depending upon the degree of the coma, will be ordered immediately and repeated doses will be given until the drowsiness disappears. The pulse should be watched and cardiac

stimulants given as needed. In many cases an enema is given and in severe cases a gastric lavage may be ordered. Sugar in the form of orange juice is administered as soon as the patient can swallow, to supply fuel, prevent hypoglycemia and aid in the combustion of fats. It should be given slowly, to lessen the possibility of vomiting. An intravenous injection of glucose may be ordered, or glucose may be administered by rectum. Fluids should be given freely to aid in the elimination of toxins and prevent dehydration. If there is no vomiting, frequent hot drinks such as tea, coffee or fat-free broths, may be given by mouth. In cases where the patient is unable to take fluids by mouth, saline solution may be given by hypodermoclysis, by intravenous injection or by proctoclysis. Patients and their relatives should thoroughly understand the symptoms of acidosis and should be instructed in the emergency treatment.

*Hypoglycemia:* If the amount of insulin given to the patient is in excess of that required for the combustion of available carbohydrates, the result will be hypoglycemia with possible convulsions, insulin shock and death. Every patient should be warned against, and should become familiar with, the early symptoms of hypoglycemia and should be instructed in the emergency treatment. The symptoms come on gradually, are easily recognized and the attack can be averted almost always by simple measures. The symptoms usually occur when the level of the blood sugar drops to about 0.08 per cent. The early symptoms are a feeling of uneasiness, and an uncomfortable sense of impending danger. There may be a mask-like immobility of the face with dilation of the pupils. An increase in the pulse rate with weakness, pallor, flushing, nervousness and tremulousness may occur. The patient often complains of marked hunger. Later symptoms are: anxiety, faintness, profuse perspiration, diplopia, and vertigo. There also may be disorientation, aphasia, and delirium. Unconsciousness and collapse are likely to result if the condition is untreated.

The treatment of hypoglycemia is to give sugar, in some form, in quantities sufficient to raise the blood sugar to

normal and to lessen the demands upon it by keeping the patient quiet. In a hospital the doctor should be notified and the patient put to bed. In the early stage the juice of half an orange may be given, or small amounts of sugar at frequent intervals. In the sweating stage, concentrated glucose (such as corn syrup) is desirable. In severe forms, when the patient is unconscious, a 20-50% solution of glucose intravenously is indicated. The solution also may be given by gavage. Sometimes adrenalin and pituitrin are given subcutaneously to convert the glycogen stored in the liver into usable glucose.

A person who is taking insulin, and is up and about, should always carry a few lumps of sugar in order to be prepared for a possible attack that might occur from some unusual exercise or other demand upon his store of sugar. Recovery from hypoglycemia, or return to consciousness is marked by tremor, twitching and mental irritability. Complete recovery is very rapid and presents one of the most dramatic incidents in modern medicine.

#### DIET THERAPY

The diet is the cornerstone in the care of the diabetic. It must be estimated for each patient and it should be so definite that the patient knows exactly what foods he may include. One of the fundamental principles in the treatment of diabetes is to avoid overfeeding. The diet should be kept within normal limits as far as possible. The caloric intake must necessarily vary with the individual but 30 calories per kilogram of body weight is generally sufficient in 24 hours for the average adult. The total glucose content (including that from protein metabolism) must not be greater than the sugar tolerance of the patient, as shown by blood and urine examinations. The proportions of carbohydrate, protein and fat prescribed vary with different doctors; however, in order to prevent acidosis, fat must be limited to an amount that can be oxidized by the carbohydrate. If the patient's own insulin is not sufficient to metabolize a required diet then insulin must be administered.

Success with patients in the regula-



tion of the diet at home depends to some extent upon a knowledge of the individual's likes and dislikes and upon the method of cooking used by the family. Adjustments can usually be made so that the patient's diet includes those foods to which he is accustomed. Physicians discourage the use of special products such as protein breads, not only because they are an unnecessary expense, but also because they are not generally available and the patient who becomes accustomed to having them experiences more difficulty in selecting meals in the average restaurant, in regulating his diet when visiting, and in many situations of ordinary living.

### INSULIN THERAPY

*Source:* Insulin is derived from the islets of Langerhans of the pancreas. It is a watery solution and may be prepared from the pancreas of animals.

*Properties:* It is not effective when given by mouth in any form available at present. It is soluble in water, but distilled water must be used since "hard" water precipitates it. It is soluble in 80% alcohol, but not 95% alcohol. Insulin syringes should not be sterilized with alcohol.

*Action:* Irritant when injected intramuscularly, it must be injected subcutaneously. It enables the tissues to utilize sugar, increases the formation and storage of glycogen in the liver, aids complete oxidation of fats, and acts as a stimulant to the para-sympathetic (vagus) nerve.

*Absorption and excretion:* Following intravenous injections, insulin appears very quickly in the urine; following hypodermic injections, it is less rapidly excreted. Excretion is complete in 24 hours. Insulin is found unchanged in the urine.

*Administration* of insulin is one of the important procedures in the care of the diabetic. Insulin lowers the blood sugar, promotes the combustion of carbohydrates, and prevents acidosis. It is not a cure, nor a substitute for the strict regulation of the diet, but it is an aid of immeasurable value in prolonging life, and in restoring the patient to health more quickly. It is given when the patient's own insulin is so deficient that regulation of the

diet alone is not enough to keep the urine sugar-free and the blood sugar normal. It is always given in diabetic coma, in the preoperative and post-operative treatment of diabetic patients and in cases complicated by infections. No set rules can be given for the dosage, time, or frequency of administration as these vary with the diet, with each individual and at different times for the same individual. Doctors differ in their methods of prescribing insulin; it is important for the nurse to see that the treatment is carried out exactly as prescribed.

There are two types of insulin widely used today and extensive experimental work is being done to develop other types. One of the types is usually referred to as "regular insulin" and the other, protein precipitate, as protamine insulin. Regular insulin, or insulin hydrochloride, is absorbed rapidly and therefore acts quickly upon the metabolic processes. Because it is a solid substance and must be broken down before it is absorbed, protamine insulin acts much more slowly and its effect is more lasting.

Some preparations of protamine insulin have zinc added to them for the purpose of still further slowing the rate of absorption. Regular insulin has its maximal effect one hour after injection and therefore is given approximately one-half hour before meals so that the body will be prepared to take care of the ingested food. Since protamine insulin is broken down slowly, a single dose in the morning produces a gradual fall in the blood sugar over more than a ten-hour period. The steadying effect of this preparation on the blood sugar, and the convenience to the patient of giving himself one hypodermic a day instead of two or three, has made protamine insulin very popular. It is used extensively now, either alone or in combination with regular insulin.

### COMPLICATIONS OF INSULIN THERAPY

*Allergic reactions:* Some individuals are sensitive to pork pancreas, which constitutes about 60 per cent of commercial insulin (the other 40 per cent being beef). These patients should be given pure beef insulin (Special In-

sulin), which is put up in 10 cc. ampules of 40 units each. The symptoms of sensitization to the protein of insulin should be watched for. These are: itching, urticaria, swelling of the lips, reddening of the eyes, puffiness of the face, weakness, epigastric pain, nausea and vomiting.

*Lipatrophy*: This rare complication consists of atrophy of subcutaneous fat at the sites of injection. This may be caused by improper rotation of injection sites, but some cases occur in spite of care. These patients should make injections at body areas which are clothed at all times.

#### GENERAL NURSING CARE

The patient's general health has a marked influence on the progress of diabetes. Constant attention therefore, should be given to his schedule in order to see that he has a sufficient amount of exercise, rest and sleep. He should be encouraged to have at least eight hours of sleep each night and to rest after exercise. Overexertion and fatigue should be avoided. Fatigue raises the blood sugar level and lowers sugar tolerance; in severe cases overexertion predisposes to coma. Exercise, however, is desirable; it increases the sugar tolerance and permits a more liberal and varied diet which means a great deal to the patient. It also lessens the amount of insulin required. The amount of exercise depends upon the patient's condition and the diet, and it should be prescribed by the doctor.

Irritability and seeming ingratitude are a part of the illness and these reactions by the patient should be sympathetically treated by the nurse. It is not until the patient can learn to enjoy the daily regime, which must necessarily be strict, that he will react satisfactorily to his illness. The nurse should help to make the planning of the patient's day, and rigid adherence to the plan, a pleasant task.

Diabetics seem to be very susceptible to infections and gangrene. It is therefore very important that the nurse help the patient to keep his skin in good condition. Bruises and other injuries should receive prompt attention. The feet require special care. They should be kept clean, warm and dry,

especially between the toes. The skin and nails can be kept soft by soaking the feet in warm water, then using lanolin around the nails. Corns and calluses should be treated, not cut. The nails should be cut across in a straight line. Shoes should be selected with care and both stockings and shoes should fit properly. Any sign of discoloration or inflammation should be reported to a physician immediately. Gangrene is to be guarded against particularly when arteriosclerosis is present because of the poor circulation and undernourishment of the tissues which occurs in arteriosclerosis.

The mouth and teeth should be kept clean and in good condition by daily care and regular visits to the dentist. While the common complaint of dry mouth and tongue, sore gums and thirst, may be relieved with treatment, it must be remembered that the mouth always harbors germs and that an infected tooth or any infection lowers carbohydrate tolerance, prolongs and increases the severity of the disease, and often interferes with its proper treatment.

The normal function of the kidneys, skin and bowels should be maintained. Constipation is common and predisposes to coma. Laxatives may be ordered, but free purging and diarrhea should be avoided because they deprive the body of fluid and alkali and thus predispose to acidosis.

Too much emphasis cannot be laid upon the importance of accuracy in the collection of urine specimens. The diagnosis and treatment of the patient is regulated by the results of urine and blood examinations. Both single and 24-hour urine specimens may be required and sometimes a specimen of each voiding within the 24 hours is examined separately. It is imperative that all specimens be collected carefully and sent to the laboratory promptly. Specimens should be kept cool to avoid decomposition; specimen bottles should be washed and boiled daily and should be kept clean.

All illnesses and infections increase the severity of diabetes and often interfere with its proper treatment. Most illnesses and infections are more easily prevented than treated. Patients should not be exposed to infection (a nurse with a cold, for instance, should not



nurse a patient with diabetes), and any foci of infection should be removed.

The nurse should not forget that accurate, complete records are essential in the care of the diabetic patient. All subjective and objective symptoms are significant, as are all factors of treatment.

### HEALTH TEACHING

As the treatment lasts through life, and must, to a large extent, be left to the control of the individual, the co-operation and education of the patient or a responsible member of his family is essential. In a hospital, therefore, "a patient is at school to learn how to save his life." The doctor should impress him with the importance of following directions explicitly and either the doctor or the nurse should instruct him in the regulation of his diet and mode of living, examination of the urine, the dosage and administration of insulin, and the danger and symptoms of overdosage; the danger of overweight and of minor illnesses and infections; and the use of emergency measures. What is expected of each patient and the freedom with

which he is allowed to modify and adjust his treatment will vary with his intelligence, persistence and self-control. He should be taught to keep accurate records and to visit his physician regularly.

### PROGNOSIS

There is no conclusive evidence that diabetes mellitus is ever cured, although prolonged amelioration of the disorder has been observed. This, however, is not a result of therapy but is related to metabolic changes in the individual associated, for example, with the correction of obesity or the healing of an infection. Although the underlying metabolic disorder may be expected to persist indefinitely, it can be compensated satisfactorily by means of a proper diet and insulin regime. These measures, together with those designed to improve the general condition of the patient, restore the diabetic to a metabolic state that is essentially normal. If treatment is begun early, before arteriosclerotic changes have appeared, and is directed skillfully and followed faithfully, there is every reason to anticipate a reasonable life expectancy.

The 1955 health record of the American people appears to have been exceptionally good, and the outlook for 1956 is very favorable. The death rate for the year will be about equal to that of 1954 which was the lowest on record.

There has been another substantial reduction in mortality from tuberculosis. Mortality from influenza and pneumonia continued at a low level. The incidence of poliomyelitis was less — the margin between the incidence in 1954 and 1955 being most appreciable during the summer and early fall months when the number of cases usually mounts rapidly.

Among the communicable diseases of childhood there was a noticeable reduction in the incidence of measles, but a rise in the number of cases of whooping cough. The number of reported cases of diphtheria, already at a low level, continued to decline. The mortality record for the major chronic diseases was about the same as for 1954. Cancer still continues to account for about

one-sixth of the total mortality. There was a small rise in the death rate from cardiovascular renal diseases. Death from diabetes showed practically no change.

The accident fatality rate was almost as favorable as in 1954. Occupational accidents continued at about the level of last year while home accidents showed a moderate decline. In contrast, the death rate from motor vehicle injuries rose. Infant mortality rates continued to improve; and maternal mortality maintained the low level of the previous year. The record of improvement in infant and maternal mortality is particularly significant in view of the high birth rate in the postwar era.

— METROPOLITAN INFORMATION SERVICE

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A smile or a laugh is far more pleasant than a frown or a growl. Anything that contributes to ease tension and create harmony in the emotional reactions of the body contributes to better health.



# Nursing Profiles

The University of Manitoba, at the spring convocation, added fresh lustre to its roster of honorary alumnae when the degree of Doctor of Laws, *honoris causa*, was conferred upon an outstanding graduate of the Winnipeg General Hospital, **Isabel Maitland Stewart**.

Born in Ontario, Dr. Stewart taught school at Morden, Man., for several years before she enrolled in the school of nursing in 1900. After graduation she engaged in private nursing for four years before becoming a supervisor at her Alma Mater. In 1909 she went to Columbia University where a course in hospital economics had been organized only a short time before by Adelaide Nutting, a fellow Canadian. Offered the opportunity to develop a program in nursing education, Miss Stewart remained at Columbia where she became successively instructor, assistant professor, associate professor and eventually professor of nursing education. Besides developing the first university program for teachers of nursing, she has written several books, countless articles and pamphlets, and has influenced nursing thought and opinion, both directly and indirectly, in every corner of the world.

Dr. Stewart's intellectual stature, her energy, her courage in speaking out, her devotion to the cause of healing, and her wisdom as a counsellor and friend have

showered recognition upon her over the years. In 1936 she was named "Woman of Achievement" by the New York League of the National Federation of Business and Professional Women. She was made Professor Emeritus of Nursing Education in 1947 and received the Adelaide Nutting award from the National League of Nursing Education. Western Reserve University, Cleveland, Ohio, presented her with an honorary LL.D. in 1948. The following year the government of Finland gave her its Medal for Humanitarian Work. Columbia University in 1954 made her the recipient of their Silver Bicentennial Medallion and conferred the Doctor of Humane Letters degree. The International Committee of the Red Cross honored her with the Florence Nightingale Medal.

In 1913, Miss Nutting said of Dr. Stewart's work: "She is bringing to the service . . . a highly trained and disciplined mind . . . a rare degree of enthusiasm and an ardent devotion to her profession and to upholding and strengthening it in its deeper and nobler ideals. The success which may attend our efforts will be due in no small degree to her." The years, and the continuing honors, have shown how true this appraisal of Isabel Maitland Stewart was.

Having an honorary degree is nothing new for **Edith Kathleen Russell**. Yet, nurses all over the world will echo the pleasure of her colleagues here in the new recognition accorded her by the University of Toronto. On May 25 the following citation was read by the University President:

No Maritime modesty inhibits my pride on this occasion when I declaim that Kathleen Russell and I grew up in Windsor, Nova Scotia, and graduated from the University of King's College. I could not then have guessed at the glowing page that she would write in the history of another King's College, the University of Toronto.

Miss Russell came to this staff thirty-six years ago as the head of a new, small Department of Public Health Nursing. Single-minded, and almost single-handed, she developed a School of Nursing that has become a lodestone and a model for leaders in nursing through-



ISABEL M. STEWART



DR. KATHLEEN RUSSELL

*with the other recipients of honorary degrees at the University of Toronto Convocation*

out the world. With a prevoiant awareness of the social significance of the healing arts, and with rigorous standards of scholarship and competence, she has proved that liberal and professional education can be successfully combined to the detriment of neither. Hers was no easy task; she has written of the founding of the school that "the path to progress has had to be cut, step by step, through a barrier raised by tradition and inertia and selfishness." How well and straight she cut that path is shown in the words that were written by the President of the Rockefeller Foundation in 1947, five years before her retirement from the University staff: "Kathleen Russell's leadership, scholarly ability and insight into the community's nursing needs have produced an outstanding research program and . . . have made Toronto one of the peaks of nursing training in the world." I would say to other divisions of this institution: "Shall we join the ladies?"

Mr. Chancellor: In the name of the Senate, I request you to confer the degree of Doctor of Laws, *honoris causa*, on Edith Kathleen Russell, whose selfless service in the cause to which she dedicated herself has influenced the lives and inspired the devotion of the international sisterhood who hold aloft the lamp of gentleness and grace.



ELSIE C. OGILVIE

During her busy career, Dr. Russell has been the recipient of many honors — D.C.L. *honoris causa* from King's College, Nova Scotia; the Mary Agnes Snively Award from the Canadian Nurses' Association, and the Florence Nightingale Medal from the International Committee of the Red Cross. She carries all of these lightly as she continues to give of her wisdom and judgment to her profession. Dr. Russell is nearing the completion of an interesting study of the nursing needs and opportunities in the province of New Brunswick. She was a leader in the original experiment, demonstrated at the Metropolitan Hospital, Windsor, Ont., which operated from 1948 to 1952.

Dr. Russell plans to reside in Toronto.

**Elsie Caroline Ogilvie** has joined the staff of the University of Toronto School of Nursing after serving for several years as nursing consultant with the American Psychiatric Association. Her experience in psychiatric nursing has been broad and varied. Previously Miss Ogilvie, who graduated from Grace Hospital, Toronto, assisted with the organization of the course in supervision in psychiatric nursing at the McGill School for Graduate Nurses. Before going to Montreal she was director of nursing at the Institute of Living at Hartford, Conn., for several years following her resignation from the post of assistant director of nursing at the Neurological Institute, Presbyterian Medical Centre, New York.

Sugar is a quick-energy food and pleasant to take. For centuries it has been used to make other foods more palatable. It does not contain any appreciable amount of vitamins and minerals, furnishing calories only.

But a level teaspoonful has only about 16 calories, not enough to make much difference. Even people on a severe reducing diet can afford to put a teaspoonful of sugar in their tea or coffee three times a day.

# In Memoriam

**Blanche Forsey**, who graduated from Lady Stanley Institute, Ottawa, in 1903, died at Ottawa on May 4, 1956.

\* \* \*

**Lois Hanly**, who graduated from Toronto General Hospital in 1922, died suddenly at Toronto on March 2, 1956.

\* \* \*

**Lenore (Lyle) Humphrey**, who graduated in 1925 from the Hospital for Sick Children, Toronto, died in May, 1956.

\* \* \*

**Mary Husband**, who graduated from Toronto General Hospital in 1906, died recently.

\* \* \*

**Caroline Legge**, who graduated from the Lorrain School of Nursing, General Hospital, Pembroke, Ont., in 1934, died there on April 21, 1956. Miss Legge had devoted much of her professional life to private nursing in New York State.

\* \* \*

**Mary Miller**, who graduated from the Hospital for Sick Children, Toronto, in 1910, died in March, 1956.

\* \* \*

**Louisa Morrison**, who graduated from Toronto General Hospital in 1907, died at Hamilton on April 15, 1956 after a long illness. After graduation Miss Morrison engaged in private nursing in Georgetown, Ont., for many years.

\* \* \*

**Jean Neilson**, who graduated from Toronto General Hospital in 1897, died last year at New Haven, Conn.

\* \* \*

**Mary (Woods) Nelson**, a graduate of St. Luke's Hospital, Ottawa, died recently following a brief illness. From 1914 to 1921 she was night supervisor at St. Luke's.

\* \* \*

**Anne (Blair) Shuttleworth**, who graduated in 1897 from the Hospital for Sick Children, Toronto, died in April, 1956.

\* \* \*

**Sister Mary Dorothea**, a member of the first graduating class of the Ottawa General Hospital died at Pembroke on April 12, 1956. Sister had given many years of efficient service in different hospitals conducted by her community prior to her retirement in 1946. She was superintendent of nurses at the General Hospital, Sault Ste. Marie, and later Superior there. She founded two hospitals in Saskatchewan at Lestock and

Esterhazy and served as Superior of each. Throughout her long life she maintained an active interest in professional affairs.

\* \* \*

**Soeur Jeanne de Lorraine** and **Soeur Marthe de l'Immaculee**, both of whom had retired from active service in the nursing profession, were among the unfortunate victims of the holocaust that followed the crash of a jet plane near Ottawa in May, 1956.

\* \* \*

**Jean (Vallance) Smith**, who graduated from Vancouver General Hospital in 1938, died at Vancouver in April, 1956. Mrs. Smith was one of the first nurses to become a T.C.A. stewardess.

\* \* \*

**Maud (Bennett) Wade**, a graduate of St. Luke's General Hospital, Ottawa, died at Ottawa recently following a long illness.

\* \* \*

**Mary Anne Wheeler**, who graduated from Toronto General Hospital in 1917, died in Florida early this year. Miss Wheeler joined the staff of the Toronto Department of Health in 1917 and retired in 1946.

\* \* \*

**Sally Ann Wiseman**, who graduated from the General Hospital, Kingston, Ont., in 1953 died very suddenly at Los Angeles on April 20, 1956. She was 24. Following graduation Miss Wiseman had worked for a year at the University of Alberta Hospital, Edmonton, before joining the staff of the Cedars of Lebanon Hospital in Los Angeles.

General hospitals, and more especially teaching hospitals, can no longer limit their activities to the treatment of physical illnesses, since such treatment would be only a partial one insofar as the needs of the community are concerned. Adequate hospital service today entails the treatment of symptoms, irrespective as to whether their manifestation is in the nature of organic or psychic pathology. These are the concepts which have played a part in the organization of the departments of psychiatry in general hospitals.

— A. E. MOLL, M.D.

\* \* \*

Difficulties should be divided into as many parts as possible. Then one may advance by degrees from the simple to the complex.



# When a Nurse Has Diabetes

DAPHNE BELL

EVERY STUDENT NURSE has had a complete physical examination before she enters the school of nursing of her choice. It is common practice for the schools to require that all remediable defects be corrected before training is started. This is only reasonable since even one abscessed tooth may cause loss of time — time that has to be “made up” at the end of training. Potential students, with more serious health problems, are wisely rejected by the schools rather than risk aggravating an existing condition by the steady demands training makes on her physical strength.

Despite all the preliminary precautions, student nurses do develop various illnesses from time to time. It may be nothing more than a simple appendix or chronic sore throat. Sometimes it is much more serious. What happens when it is discovered that a student nurse in her intermediate year has developed diabetes mellitus? Should she be required to give up her training? The story of a fellow-student, whom we shall call Sheila Forbes, may bring fresh hope and courage to other girls with diabetes mellitus who may wish to enter the profession of nursing and who will have to learn to adapt themselves to the irregular hours both student and graduate nurses have to work.

Sheila was normally healthy as a youngster. Apart from the minor communicable diseases, the only unpleasant break in her health picture was sinus trouble at the age of 12. She had severe prefrontal headaches that sometimes recur, still, in damp weather.

Training was started in September, 1953, at 18½ years of age. By the time the symptoms of diabetes developed in November, 1954, the “probie” period, the Junior block lectures and the Junior R.N. examinations were all behind her.

Sheila was completely asymptomatic all through that first year. It was after

she had started her experience in the operating room that she noticed that she was losing weight. Unlike some of her classmates, whose weight had soared during their first year, Sheila had remained fairly constant at around 115 pounds. She became concerned at the rapid loss of weight which was just 96 pounds when she reported off duty. She had begun to feel very, very tired but, thinking it was a normal result of the bustle in the operating room she did not attach much importance to it.

Three weeks prior to admission as a patient Sheila realized that the four or five times she had to get up at night was abnormal. Though the frequency and polyuria bothered her, she reckoned that it was the quantity of fluid she was taking, for her mouth was always very dry and she was extremely thirsty. Though she became hungry more often Sheila did not suspect diabetes. True she had learned the symptoms in the course of her medical lectures but diabetes was something that happened to somebody else — not yourself or your friends!

Eventually blurring of her vision precipitated a request for a medical examination. Sheila had worn glasses for five years because of myopia but no change of lens had been necessary when last her eyes were checked. She felt very listless and weary and though there was no dyspnea she had noticed more strain and palpitation whenever she climbed stairs.

When she was admitted to the diabetic unit on November 30, 1954, the urine showed 4 plus sugar and 2 plus acetone. The a.c. blood sugar was 366 mgm.% with the p.c. blood 588 mgm.%. Hemoglobin was 94%, white blood count 6,200, Immediate enquiry did not reveal any hereditary factor of diabetes.

The initial step in treatment was to start the patient on a low calorie diet that would be gradually increased to find out to what extent the disease could be controlled by diet alone. The aims of dietary treatment are: to lower

Miss Bell graduated last spring from the Royal Victoria Hospital, Montreal.

the blood sugar; to counteract acidosis; to supply nourishing food to help the patient regain the lost weight. Sheila's diet was soon supplemented by insulin as follows:

*Initial diet:* Protein 50, Fat 50, Carbohydrate 50. No insulin. This regime lasted for three days. All the carbohydrate was lost in the urine. Since only meagre amounts of food were allowed, Sheila summed it up as "I was horrified!"

*December 3:* P. 80 F. 50 CHO 90. Protamine zinc insulin, 20 units before breakfast.

*December 4:* P. 80 F. 50 CHO. 110. PZI 28 units before breakfast. The urine showed 4 plus sugar and 4 plus acetone.

*December 5:* P. 80 F. 50 CHO. 130. PZI 40 units before breakfast, Crystalline Zinc Insulin 40 units during day. Both sugar and acetone remained 4 plus.

*December 6:* A close watch was kept by both the patient and the nurses on the ward, for an insulin reaction following the increased dosage. Exactly the opposite reaction occurred. During the night and early morning, Sheila began to vomit, felt weak and dizzy when she attempted to get out of bed. As these symptoms became more acute, she developed a headache, an acetone breath, a dry skin and a tremendous thirst. Acidosis was increasing rapidly so she was given an immediate dose of CZI and an intravenous of 5% glucose and saline was started. She received 76 units of CZI during the day with 20 gram feedings every three hours.

*December 7:* The doctors noted that the protamine zinc insulin alone was ineffective in controlling Sheila's diabetes so decided that she should be given both kinds. On this day with 80 units of CZI only, the urine was free of sugar and acetone.

*December 10:* The diet was increased to P. 100 F. 50 CHO. 230 with PZI 32 units, CZI 32 units before breakfast and CZI 24 units during the day. Only 10-15% of the total carbohydrate intake was now being lost in the urine. The crystalline zinc insulin was both successful and effective.

It was decided that for her own protection in the future it would be well to have Sheila experience a sharp insulin reaction. An overdose was given deliberately, therefore, with the charac-

teristic sequence of ravenous hunger, shakiness, perspiration, apprehension and a waxy white nose. Sheila quickly learned the importance of counteracting this reaction!

Before she was discharged on December 18, Sheila's diet was established on the basis of P. 100 F.60 CHO. 250. The insulin dosage was set at PZI 36 units, CZI 24 units before breakfast and CZI 20 units before midday dinner.

Even after two weeks at home, Sheila felt somewhat shaken by her experience when she returned to resume the life of a student nurse. At first she always felt hungry but gradually she became accustomed to her new regime. While she was a patient, she had attended the lectures that are given to diabetic patients. She knew that unless sugar is found in the urine, blood sugars are taken every three months. It became routine for her to test her urine twice a day — before breakfast and in the afternoon. Having spent six weeks in the diabetic ward prior to her illness she was well informed about the disease, its complications, its limitations and the problems of adjustment.

Sheila's return to active duty was an indication of the splendid adjustment she made. Her meals have all been prepared in the diabetic kitchen. She carries with her all the necessary equipment for her own dose of insulin and half an hour before her meals she administers the correct amount.

Understanding and faith between the patient and her doctor go a long way to securing the necessary mental adjustment to the new way of life that confronts a person who has diabetes. Shall she carry half a load or her full share? What about hours of work? Should she be scheduled only for day shift, skipping evening and night duty? Following consultation it was agreed that Sheila should follow exactly the same pattern of duty as all her classmates. It has been necessary to notify the diabetic kitchen the day before shift changes are made so that her meals can be properly spaced.

Diabetes mellitus is not communicable, like tuberculosis; it is not painful, like arthritis; it is not unsightly like some dermatological conditions. But diabetes is a chronic disease. As

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she nears the conclusion of her time as a student. Sheila knows that she will always have to watch her diet —

always have to take insulin. But she also knows that she will be able to carry on in the profession she loves.

## Impressions d'Afrique

CLAIRE (DESMARAIS) TREMBLAY

J'AI INTITULÉ CETTE CAUSERIE: Impressions d'Afrique, pour deux raisons. Premièrement, impressions, parce que les 30 mois que j'ai vécus au Tanganyika, n'ont pas suffi à créer des certitudes, des opinions arrêtées; les problèmes de ce pays, pour moi si nouveau et si complètement différent de notre Canada, sont trop sérieux, trop complexes pour que je me permette de vous exprimer rien de plus qu'une appréciation tout à fait personnelle.

Deuxièmement, parce qu'un moment, une soirée sont trop brefs pour détailler tant de parcours: de Montréal en Europe et jusqu'au Tanganyika puis du Tanganyika jusqu'au Cap de Bonne Espérance et enfin du Cap au Caire et à Paris; aussi tant d'expériences, la vie d'une canadienne sur une mine de diamants au coeur de l'Afrique; enfin toute la splendeur de la grande Nature.

Le voyage de Montréal à Nairobi, puis à Mwadui avait un caractère bien touristique, puisqu'il s'est fait par bateau, par trains, par avion, enfin par tous les moyens conventionnels, avec des billets qu'on achète au départ et des horaires fixes.

Un impressionnant navire, nous transporta de New York en Angleterre. Pour notre séjour en Grande Bretagne, nous avions loué une auto et un de mes nombreux préjugés devait se fondre sous le charme de la campagne anglaise. Puis d'un bond d'avion nous sautions de Londres à Paris. Une semaine à Paris: c'est vraiment trop peu pour y apprendre l'art de flâner! De Paris à Interlaken: une agréable randonnée en train. Comme tant de touristes, nous sommes

montés à la plus haute station d'Europe pour admirer le Jungfrau. A regret nous quittons la Suisse toute blanche, toute propre, si gentille, pour descendre vers Rome d'où nous nous embarquons dans un gros avion pour une migration vraiment importante: une envolée de 22 heures, entrecoupée de quelques escales rapides: Le Caire, Karthoum, Entebbe, et le but: Nairobi — le même Nairobi qui a apparu dans les journaux montréalais à l'occasion de la guérilla des Mau Mau. Quand nous y sommes arrêtés pour la première fois, en novembre 1951, la ville semblait très sereine. Pour moi, c'était l'Afrique. J'arrivais dans une ville, bien sûr, mais je m'y sentais très craintive; le première nuit passée en terre africaine, fut pour moi, lourde de cauchemars de serpents, de massacre de missionnaires, et de mille aventures tirées des contes d'enfants.

Dès le lendemain, un des avions de la compagnie pour laquelle Mousseau, mon mari, allait travailler, nous emportait de Nairobi à Mwadui. Mwadui, située à 200 milles au sud de Nairobi et à 90 milles au sud-est du Lac Victoria, est une agglomération qui a poussé il y a seize ans à la suite de la découverte d'une mine de diamants par le Dr. John Thorburn Williamson, (Ph.D. en géologie), canadien, originaire de Lachute, Qué.

Mwadui nous accueillit, mon mari et moi-même, avec amitié. Le soir même de notre arrivée commença notre vie sociale qui devait être des plus agréables pendant tout notre séjour. Ce premier soir, nous étions les invités du géologue en chef qui avait réuni également les autres membres du département de géologie. Nous devions par la suite connaître de profondes amitiés chez des anglais, des sud-africains, des hollandais et des allemands.

Le lendemain commença pour moi

---

Mme Tremblay, diplômée de l'hôpital Notre-Dame de Montréal est l'épouse d'un géologiste, employé à des recherches à la mine de diamant en Afrique.

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une expérience inattendue: j'avais à mon service, trois nègres qui ne parlaient ni anglais, ni français, mais une langue tout à fait sortie des nues, qui s'appelle le Kiswahili, que je devais apprendre assez bien dans les premiers mois suivants. C'est une langue mi-bantu, mi-arabe, régie par des règles de syntaxe bien définies, et dont l'étude rapporte à celui qui s'y adonne, une véritable satisfaction en même temps qu'un épanouissement de l'esprit.

La vie, à Mwadui, même était très plaisante; en plus de l'occasion qu'on y avait de rencontrer des personnes de cultures différentes, on y jouait au tennis, au golf, on se rafraichissait à la piscine. Le Club donnait deux soirées de cinéma par semaine; des danses, des mascarades, des concours d'adresse.

La nourriture la plus fine, les légumes nous venaient par avion de Nairobi; la viande, les oeufs et le lait étaient des produits locaux. On ne manquait vraiment de rien. Les maisons recouvertes de stucco blanc et de toits de tuiles rouges avaient des intérieurs spacieux, bien éclairés, meublés confortablement avec toutes les aménités de la vie moderne: eau chaude, poêle électrique, frigidaire, etc.

La première adaptation à faire pour des personnes qui viennent des pays froids est celle de s'habituer, non pas à la chaleur, mais à la lenteur de toutes choses. Mais si l'on surmonte sa première réaction qui en est de mécontentement peut-être ou de nervosité à devoir subir l'inefficacité des services, des accomplissements, alors on connaît une règle d'or.

Pour ma part, ce ralenti, cette halte, me donna le loisir de réfléchir plus sérieusement, et de considérer sous un angle différent l'ensemble des valeurs matérielles et spirituelles. Et tout absorbée par ces méditations je n'ai pas réalisé à quel moment, ni jusqu'à quel point, les cieux africains avaient comblé mon coeur.

A Mwadui, il n'y pas de froids, de pluies ou de chaleurs excessives. La mine du Docteur Williamson est située à 4,000 pieds au-dessus du niveau de la mer. Croyez-moi, je n'ai jamais souffert de chaleur écrasante comme on en subit dans la région de Montréal l'été dernier. La saison des pluies se manifeste par un orage vers quatre

heures de l'après-midi et se prolonge très rarement plus qu'une demi-heure ou une heure. Après quoi tout rayonne de nouveau. Pendant trente mois, je n'ai pas vu une journée sans soleil, c'est tout dire! Les pluies rafraichissent les soirées et les nuits qui par ailleurs, ne sont jamais très chaudes.

Quand on s'ennuie un peu du froid et de la neige on n'a qu'à faire une excursion au Kilimanjaro qui s'élève à 19,000 pieds et dont les sommets sont couverts de neiges éternelles, toutes illuminées qu'elles sont, par le soleil de l'équateur. Le Kilimanjaro est situé à 200 milles de Mwadui. Et si l'on veut s'ébattre dans les eaux d'une véritable mer intérieure on se dirige vers le lac Victoria, 90 milles au nord de la mine; le lac Victoria est le deuxième plus grand lac au monde après le lac Supérieur.

L'un des charmes les plus prenants du Tanganyika réside certainement dans sa faune extraordinairement riche et variée. On n'a qu'à parcourir quelques 60 milles pour admirer des troupeaux considérables de zèbres, de gnus, de Hartbeest, de giraffes, d'antilopes de toutes espèces, de quantités de singes, de buffles. Si on a de la chance on apercevra des éléphants, occasionnellement un lion, un léopard, ou un rhinocéros. Près d'un cours d'eau on pourra voir des hippopotames ou des crocodiles. Et tous ces animaux dans leur habitat naturel ont une beauté exceptionnelle. Les oiseaux sont aussi nombreux que variés et leur colori est souvent absolument extraordinaire.

La fore plus réduite à cause de la semi-aridité de la steppe, de ce plateau de 4,000 pieds d'altitude, comporte quand même des arbres et des plantes d'une splendeur et d'un parfum exquis. La plupart des maisons de la mine se parent de bougainvillée rouge vif, violet ou orange. Les jardins sont souvent surchargés de frangipaniers, de poinsettias, de begonias, d'hibiscus pour ne mentionner que les plantes les plus communes. Les arbres qu'on voit le plus fréquemment sont les acacias, les baobabs, les palmiers, les bananiers, les papayas, les manguiers.

Tout au cours du travail de Mousseau, nous avons eu la chance de parcourir le Tanganyika du nord au sud et de l'est à l'ouest. Pendant ces voyages qui duraient parfois quelques





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**E**VEN premature infants digested, utilized and retained the proteins and fat in specially prepared Meats for Babies according to Sisson, Emmel & Filer, “Meat in the Diet of Prematures”, Pediatrics, 7, 89 (1951).

The authors state, in part: “Meat protein is as well retained and utilized as milk protein by the premature infant and is therefore as safe and efficient a source of protein as milk. The fat absorption of the premature infant is not significantly altered when the milk in the diet is partly or wholly replaced by meat fat or meat fat and olive oil.”

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*cooked and milled to a fine purée. The texture is soft, moist and easily fed in formula or for initial spoon feeding just as it comes from the can. There are seven kinds for variety and special conditions: Beef, Lamb, Pork, Veal, Liver, Heart, Liver and Bacon, and also Swift's Egg Yolks for Babies, Salmon Seafood for Babies and the chopped Swift's Meats for Juniors.*

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jours, parfois un mois, je me suis habituée à la vie de camp et-à tous ses avantages.

Notre premier garçon avait un mois quand nous l'avons amené faire son premier voyage. C'était dans le temps de Noël et nous voulions aller voir le cratère de Ngorongoro, l'un des plus spectaculaires au monde. Le voyage, une distance de 200 milles, sur des pistes peu connues, affecta si peu le comportement du bébé que nous n'avons plus jamais hésité à amener d'emblée la famille entière dans toutes nos excursions.

Lors d'une vacance de six semaines, nous sommes descendus jusqu'au Cap de Bonne Espérance. Nous avons admiré les Chutes Victoria, le majestueux fleuve Zambèze, la chaîne du Drakensberg, la Montagne de la Table

d'où l'on admire l'océan Indien et l'océan Atlantique qui viennent se joindre et se heurter à l'extrémité sud de l'Afrique.

Et si notre voyage d'aller pouvait être classé comme voyage de touriste, celui de notre retour fut toute une odyssée. Nous avons quitté la mine du Dr. Williamson en avril 1954, dans une petite camionnette qui nous transporta à travers l'Ouganda, le désert de Nubie (Soudan) l'Egypte, le Liban, la Syrie, la Jordanie, la Turquie, la Grèce, la Yougoslavie, l'Autriche, la Suisse et la France. Ce fut une grande expédition préparée pendant plus de dix mois, et qui s'effectua sans encombre, nous donnant l'opportunité de connaître plus pleinement la gloire de la Terre et la joie de vivre. Et pendant la traversée de l'Atlantique, nous rêvions encore du Tanganyika.

## Sélection

### *Petite Etude Psycho-sociale*

La T.V. met-elle obstacle aux bonnes relations familiales et sociales?

La télévision dès son apparition nous apporta non seulement des exclamations et des interjections, mais aussi des points d'interrogation. En un mot, elle a de nombreux avantages et beaucoup de désavantages. La télévision peut être un instrument éducatif et culturel ou banal et déformateur. Tout cela provient de la manière dont on l'utilise.

Pour bon nombre de personnes la télévision est une occasion de paresse intellectuelle: la lecture est mise au rancart; adieu les efforts de concentration et d'assimilation, ici tout est servi prêt à absorber, c'est beaucoup plus simple.

Elle est pour plusieurs spectateurs, qui savent faire le choix de leurs émissions, une source culturelle et enrichissante tant au point de vue moral qu'intellectuel et social.

Dans plusieurs foyers, le mari se voit délaissé pour le grand "Survenant" ou le beau "Guillaume," et la femme regarde d'un oeil jaloux son époux qui semble si intéressé à un programme de "Music Hall."

Pour les enfants et les adolescents, la T.V. peut être une ressource éducationnelle et instructive ou déformatrice et suggestive.

Je trouve que la T.V. nuit beaucoup à nos belles veillées d'autan. Tous les soirs, elle est là qui sollicite notre attention et elle

semble vouloir accaparer tous nos loisirs pour elle seule. En songeant aux joyeuses soirées d'amitié d'hier, je me prends à regretter cette invention d'aujourd'hui. Tout le monde n'a d'yeux et d'oreilles que pour les personnages de cet écran, sans penser que, près d'eux peut-être, quelqu'un aurait besoin d'un sourire, d'un bon conseil, d'un encouragement, d'une causerie amicale, etc.

S'avise-t-on de visiter des amies, aussitôt des chaises sont avancées devant ce fameux appareil et les regards nous disent: "Ch... Ch... pas de bruit," comme si nous étions venues spécialement pour voir le charmant sourire des vedettes.

La T.V. ne présente sûrement pas que des mauvais côtés; elle a de nombreux avantages, mais il faut s'en servir intelligemment et non "gober" tout ce que l'on nous sert. Il faut être capable de regarder et d'apprécier certains programmes et de rejeter certains navets.

Ne trouvez-vous pas qu'il est grandement temps pour nous de réagir et de faire un choix des programmes à suivre? Ne pas y assister en spectateurs inactifs mais savoir tirer profit des heures passées aux télé-spectacles.

Extrait de "Sentinelle", journal des étudiantes-infirmières de l'Hôpital Saint-Jean, Saint-Jean, P.Q.

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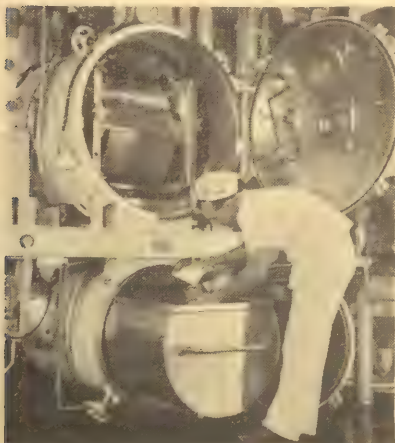


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# A New Deal for Male Nurses

ALBERT WEDGERY, *Reg. N.*

**D**URING THE RECENT annual convention of the Registered Nurses' Association of Ontario, an event took place that was unique in the annals of that organization. For the first time in the history of the R.N.A.O., and perhaps in Canadian nursing, a group of 23 male nurses, representing approximately one hundred registered in the province, gathered at a special luncheon meeting to discuss the particular problems facing their segment of the profession.

While earnestly desiring to encourage closer unity among male nurses engaged in various types of nursing throughout Ontario, this small but eager band assembled in the hope that, as a result of this long-overdue meeting, a way might also be found to stimulate more interest in the training of male nurses. Consequently, after an animated discussion period that was the highlight of the luncheon, a Male Nurses' Committee was formed. It was later approved by the Board of Directors of the R.N.A.O., thus assuring

this new group of a direct channel of communication within the parent association. Needless to say, this precedent-breaking occasion aroused considerable interest in several quarters, in particular, among the members of the press whose assistance was invaluable not only in bringing the event to public notice but also in repairing the general lack of information regarding male nurses.

While this unusual gathering served the purpose of drawing male nurses together in a common interest, it could not fail to underscore their woefully small numbers in comparison with the overwhelming body of female nurses. This overpowering discrepancy is a clear indication that the training of male nurses has become almost negligible in this country for, with the exception of Ontario and Nova Scotia, it appears that no other province is making more than a limited attempt to attract men into schools of nursing.

Moreover, judging from the outcome of an inconclusive report of the Committee of Nursing Education of the Canadian Nurses' Association in 1948, which had set up a sub-committee to examine courses of study for the preparation of male nurses, little progress has been made in this direction since that time. Since World War II increasing numbers of men in Great Britain and the United States are entering the profession due to an enlightened policy of nursing education, but there has been a noticeable reluctance on the part of most Canadian schools of nursing to institute this training as one possible means of fulfilling the growing demands for nursing service.

This general unwillingness to establish a new trend in nursing prompts an important question: are the leaders of the nursing profession in Canada



ALBERT WEDGERY

Mr. Wedgery, who is chairman of the Male Nurses Committee of the R.N.A.O., is a member of the teaching faculty at the General Hospital, Oshawa, Ont.

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today, and those closely associated with its current needs and problems, making an intensified effort to reduce the existing shortage of nursing personnel by exploring all possible avenues of recruitment? Beyond a few experiments on a small scale, little or no endeavor is being made to attract men into a type of work that was, until comparatively modern times, shared by members of both sexes.

Apart from the tradition that has surrounded it during the last century, there is actually no justification for nursing to remain an almost exclusive female occupation. The record of history shows that through medieval times right up to a recent period, men belonging to religious brotherhoods and military orders assumed a large share of the nursing duties. If newer evidence is sought, it can be found in the experiences of the armed forces during World War II when it was proved that men who had not previously performed this work were able to give satisfactory bedside care. Naturally, all men do not answer the requirements of nursing, but as the number of potentially competent male nurses is large, an aggressive campaign directed toward the recruitment of this virtually untapped source would seem a sensible move.

However, before the nursing profession can hope to draw men in large numbers into schools of nursing, it must first face the problem of making the long period of preparation both palatable and profitable. Are the working conditions and rates of pay in nursing today, before, and after graduation, sufficient to attract a young man searching for a career? More than at any other period in the past, the recruitment of nursing personnel is strongly influenced by the conditions of employment and the rewards to be gained throughout and after the period of training.

While it is true that incentives in nursing should go beyond purely monetary considerations and insure particularly an opportunity to grow professionally, there can be no denying the fact that nursing is losing to competing occupations many capable individuals who are disenchanted by its incongruous position at the economic

bottom of the professional ladder. In fact, many male nurses, dissatisfied with the anomalous situation of nursing in relation to other professional groups, have sought other means of livelihood that will guarantee them financial security to meet family responsibilities. Thus, if nursing today wishes to attract men who will accept it as a lifetime vocation, it will have to provide assurance of increasing professional prestige as well as greater economic protection in the form of long-range benefits.

Nevertheless, in this present era of tremendous hospital expansion, with its accompanying demands for larger numbers of qualified nursing personnel, schools of nursing across Canada are offered a splendid opportunity to create meaningful careers for young men. Up to the present time the training of male nurses has been almost entirely restricted to mental institutions. Perhaps some enterprising general hospitals, confronted with prevailing shortages of nursing staff, will rise to the challenge and investigate the possibilities of changing their training schools to coeducational establishments. By the adoption of realistic and far-sighted policies calculated to entice able and interested young men (and women) into satisfying careers, nursing will find itself competing with other occupations on a more equal basis. Furthermore, if considerable numbers of men could be persuaded to embrace nursing as a lifetime work, there is every likelihood that this influx would raise the income level of the entire profession.

Men have a significant role to play in Canadian nursing, but their contribution to its progress and development will remain inconsiderable until new and vigorous measures sweep away the barriers now preventing their entrance in larger numbers. In order to overcome the many difficulties of such a move, people with vision and initiative must give definite leadership to a forceful educational policy fraught with benefits to every branch of nursing. Once men are convinced that a career in nursing can be a rich personal experience while providing financial independence, it will be the dawn of a new and important phase in Canadian nursing.



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# Life, Profession and School

SIR FRED CLARKE

(Continued from July, 1956)

First, then, as to *objectives*. The chaos about aims which now characterizes the educational field is but a reflection of the wider chaos that is paralyzing Western civilization as a whole. We seem to be passing through the profoundest moral and spiritual crisis that mankind has experienced since Greek times, and no man can say what will issue from it. I do not propose to go into its causes: they are a matter for the interpreter of modern history. Nor do I doubt that we shall come through: Western civilization is not going to collapse. Here, however, I ask you merely to take note of the fact itself, patent as it is to us all.

A solution of our deep and painful perplexities cannot come wholly from the educational end. But it must, very largely, begin there, and it can hardly come at all unless those who have charge of education achieve a pretty clear consciousness of the direction in which a solution is to be sought. The burden of the pioneer and the scout is thrown upon the educator today as never before. He cannot escape the responsibility for a leading part in the drastic revision and re-integration of Values that is called for, and in the building up of those stable and adequate *Standards* that we so sorely need. Even so, his power may not be equal to his vision; his reach may exceed his grasp. But that is hardly his fault.

Let me repeat that the root problem is moral and spiritual, one of the reconstruction of stable values, and of a sure discipline to achieve those values.

I should like to be allowed to illustrate our problem by reference to three books which, for me at least, when taken together, state the issue with a most helpful clearness.

The first is H. G. Wells' "Work, Wealth and Happiness of Mankind"; the second is Aldous Huxley's "This Brave New World"; and the third, D. H. Lawrence's "Apocalypse."

Mr. Wells' book is the last member of his trilogy on the foundations and prospects of our modern world, the other two members being his "Outline of History" and his "Science and Life." This latest book may be not unfairly described as a glorification of the practical ingenuity of man's intelligence and of the unlimited possibilities that lie open to his inexhaustible inventiveness. The note of the book is strangely reminiscent of the voice of King Nebuchadnezzar as he walked in the palace of the Kingdom of Babylon: "Is not this great Babylon that I have built for the house of the Kingdom by the might of my power and for the honor of my majesty?"

We know what the consequence of that performance was, but Mr. Wells shows no sense of it at all in the analogous case. The prospect he paints is that of a vainglorious and rather vulgar Triumph of Technique. Witness, for instance, the snap and click of the highly polished "Efficient" Parliamentary system that he devises. The crucial word "Happiness" occurs in his title, but it is nowhere defined in the text, nor does it occur in the index. Neither does the word "Character." We are left to assume that the Triumph of Technique *is* Happiness, and Art, Poetry, Literature are handled in a very brief section where they are treated as the expression of man's superfluous energy.

Salvation comes, therefore, through engineering! Yet, inadequate, and indeed degrading, as the Wellsian conception is, it, or something very like it, serves as a seemingly satisfying ideal to many at the present time.

Aldous Huxley's "This Brave New World" is a biting study of the Wellsian ideal come true. Science and technique and the calculating intellect have triumphed: war and disease, poverty and maladjustment are no more: even the pangs of birth and the risk of misfits have been circumvented by elaborate prenatal treatment which utilises all the latest in biochemistry.

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The intrusion into this world of a savage, who has, by accident, got hold of a neglected Shakespeare, causes a riot and, incidentally, gives Mr. Huxley the chance to say what he thinks of it. The whole thing may be summed up as: *Pigs*, without even the excuse of dirt.

Whatever one may think of the details, the moral of it all is clear. The conquest of war and disease and poverty is not the end of our problem, but the beginning of it. When we have got thus far we shall be faced more nakedly than ever with the inescapable problem of the Art of Life itself. Man can use science to conquer ills; but he can also use it to condition himself so as to become quite insensitive to the whole range of what we used to call the "higher" values. Is he to describe as "Happiness" the well-washed but brutish contentment that might ensue? Is it not rather the case that Beastliness plus the clinic and the bathroom is Beastliness still; if anything rather worse than the primitive unwashed kind?

That seems to be Mr. Huxley's moral, and some current tendencies in life and education seem to be not a little concerned in it.

The third book, D. H. Lawrence's "Apocalypse" is the profoundest of the three. It is such a passionate unity and it makes such efforts to use language to express the inexpressible that quotation is hardly possible. But its general burden is plain. Lawrence puts his finger on the overgrowth of the inventive intellect — the Logos, as he calls it — as the root cause of our modern disease. His own self-torment in the search for a remedy should warn us that the quest is not easy. Also it is full of danger, as Lawrence's own writings show. Fullness of Life is made to look like a perilous

walk along a sort of knife-edge with a chasm of beastliness on either hand, that of Caliban on the one side and that of Babylon on the other. But there is good Christian precedent for such a view, without involving ourselves in the negations of Puritanism.

For our present educational purpose it may be enough to say that what we are faced with is the need for an infinitely delicate and pliable *discipline*, that can be diversified and variable in its play just because it is so sure of its end, and that can guarantee freedom and fullness without falling into sophistication. I want to stress this word "Discipline," as the necessity for it seems to follow from all that has been said about the lack of true and adequate standards and the chaotic operation of false and inadequate ones. Reach agreement upon standards and the discipline follows. Hence I think it is not untimely to state our problem as one of the Reconstruction of Discipline. The point is important in the present connection just because of that peculiar *representativeness* of nursing which I have already emphasized. The nurses' professional *expertise* will be a poor and shrivelled thing — it may even be a dangerous thing — unless it springs from and is rooted in a large and liberal human discipline such as we are now contemplating. She is the representative of a culture as well as the bearer of healing, and she cannot well represent what she has not learned to possess.

Now this word "Discipline" is not popular today. I know. But that is largely because of the company it has kept in the past. When we hear it we think of its old, unpleasant associations without pausing to analyze its real and necessary content. But to purge and reform the concept is one thing; to throw it away is quite another thing, as calamitous as the proverbial throwing away of the baby with the bath. For all education that is not a blind and cowardly surrender to whim and impulse is discipline. It involves always a choosing of this rather than that; it is indeed one long series of choices of the better over the worse. Where there is choice there is a standard, explicit or implied, and that standard is conceived in terms of the good of the disciplined one. The old

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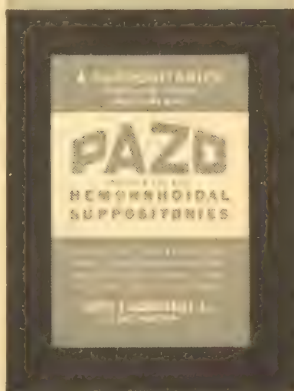
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discipline erred in method rather than in end. It took too little trouble to secure an *internal* discipline, to identify the positive will of the pupil with the aims of the tutor, and so with his own good. For it, the will of the pupil was the obstacle, not the hope. John Wesley, when he urged an anxious mother to "break the child's will" at all costs, was wholly benevolent in his intention; we can hardly say he was wise in his method.

What we have to do with the concept of discipline, therefore, is to revise its method, not to throw it away. It is by no means the only example of a salutary idea that is apt to be thrown away in these heady and over-sentimental times just because of past prejudices and because we lack either the wit or the will to make a right use of it.

Our notion of a Reconstruction of Discipline implies, then, a comprehensive ideal of self-building that will give to both individuals and society a satisfying moral and spiritual *shape* within which all the fullness of diverse human possibilities can be realized. The Greeks had such an ideal of shape — within limits. Medieval Christendom had one too, also within limits. But the course of the last few centuries of history has been all against any reconstruction of it. Yet it is what we are all fumbling after in blind and somewhat perverse fashion. If ever we do again achieve some approach to such an ideal it will have to be something far richer and wider than any such ideal has been in the past. For it will have to cover a much wider range of human possibilities; it will have to include and provide for a vast number and variety of individuals; above all, it will have to provide for a discipline that is freely accepted, positive and *internal*, if it is to satisfy modern man.

But we must achieve it if we are to educate at all with effectiveness and confidence. Without it, education becomes either the application of false disciplines to distort a natural humanity, or a sprawling, shapeless, aimless thing with no discipline at all and hiding its real nature under a mush of uncritical sentimentality about "Freedom."


When it becomes possible again to

apply in Education a full concept of Discipline, fearlessly and confidently, we shall see a considerable shifting of emphasis among current ideas. Thus there will be less of problem-solving and more of the heightening of sensibility and awareness; less of interest-following and more of willing and choosing; less of the group-activity and more of the contemplative self; less of either license or prohibition and more of self-restraint; less of endless invention and "re-making" and more of absorption in and attunement to an ideal that finds expression all around. We shall move, that is, away from a misunderstood Rousseau towards a better understood Plato. We shall depend less upon things and more upon ideas; we shall gain in quiet sensitiveness without losing in eager curiosity.

If we can restore a large and liberal conception of Discipline in this sense our problems of vocational education will be solved in so far as their solution depends upon an adequate preliminary general training. Where all are trained to respond actively and sensitively to the values of a rich common ideal, with a training which runs less risk than ours does today of degenerating into an aimless and meaningless scholastic ritual, the subsequent vocational preparation will have in view not the *compartmentalizing* of a little special corner of the common life, but the expression of the common life as a whole through one of its typical functions. The thought is quite platonic in spirit. The nurse is the community nursing; the teacher is the community teaching; the tailor or cobbler the community patching; and so on. In our present divided, chaotic, undisciplined state the thought may seem visionary enough. Nevertheless, the attainment of something like it is the key to the true solution of all our problems of educational objective.

My reason for dealing thus fully with this fundamental matter of a General Discipline should now be sufficiently clear. The picture would be wholly incomplete without it. I have been struck by the emphasis that experienced nurses themselves place on this matter of general education. They realize, I think, that nursing does not





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eminent degree for just those refined and developed human traits that it is the business of liberal education to provide. Do I not claim rightly that no better and more representative field for testing out our principles can be found than this of the education of nurses?

*(To be concluded next month)*

Agricultural scientists have developed a machine that sterilizes fresh vegetables and fruit so that they stay fresh for extended periods without any need of refrigeration. The device is called a cathode ray machine. It is used to irradiate the vegetables. In one experiment, researchers found that beans, treated with rays from the machine, had a much longer period of freshness than ordinary beans or even those kept in refrigerators. The machine can also kill insects in grain without harming the grain. This means, according to the researchers, that wheat and corn, for example, can be preserved in storage places much longer than ever before, without the losses caused by the depredations of insects.—(ISPS)

Chlorpromazine, a valuable sedative in the treatment of mental illness, is converted in the body into a substance which may have even greater value. The new compound is known as chlorpromazine sulfoxide. It appears to exert the same tranquillizing effects as the parent drug but seems to lack at least one of the undesirable effects — production of postural hypotension. This side effect was extremely objectionable to patients taking chlorpromazine for long periods of time. At the present the new derivative is still in the stage of animal experimentation but clinical trials on humans are planned in the near future.

— U.S. DEPT. OF HEALTH,  
EDUCATION AND WELFARE

## In the Good Old Days

*(The Canadian Nurse — August, 1916)*

The most usual practice, when applying saline dressings to an infected wound, is to place a thick packing of dry cotton-wool immediately next to the wet dressing. The idea seems to be that the cotton-wool will soak up the discharges and by its capillarity and the evaporation from its outer surface reinforce the drawing action of the salt. In point of fact, however, all the cotton-wool does is to suck out some of the salt solution from the dressing and evaporate this, thus putting a certain quantum of salt out of action.

The rational method of covering wet saline dressings is to apply an impermeable covering. Then the salt solution, instead of evaporating, will be carried inward. Use cotton-wool outside the jaconet.

\* \* \*

A new pattern has come into use in the teaching of surgery that is indeed novel and interesting. Outstanding surgeons can

now operate before moving picture cameras so as to show the whole technique. Thus committed forever to the film, any one may project any part of the event on a screen simply by turning a handle.

\* \* \*

In at least one town in Ontario there has been an epidemic of poliomyelitis. Every case must be quarantined for six weeks and all children who have been in contact with the patient quarantined for two weeks.

\* \* \*

An insect in the ear may cause great alarm. The easiest way to remove it is to fill the ear with warm water. As a rule, within ten minutes the insect floats to the surface. Another way is to smoke the intruder out by blowing a steady stream of tobacco smoke into the ear.

\* \* \*

On Friday, June 16, the nurses present at the C.N.A. convention discussed an im-

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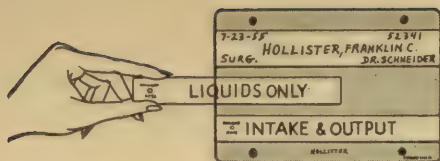
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- (5) Zone Supervisor of Nursing, Box 292, North Bay, Ontario.
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portant question — the advisability of the Association purchasing *The Canadian Nurse* and publishing it as the official organ of nursing affairs in Canada. The Association has decided to purchase the publishing rights to the magazine. Miss Helen Randal a graduate of Royal Victoria Hospital, Montreal, who has been superintendent of nurses of the Vancouver General Hospital for the last four years, has been appointed as the new editor of the magazine.

## Canadian Nurse Award

Presented first in 1951, *The Canadian Nurse* award was offered to the student in the graduating class of each school of nursing in Canada, selected as showing "the greatest promise of professional development", and took the form of a two-year subscription. In those provinces where graduates received the *Journal* through their registration fees, a cash award was substituted. As the provinces have, one by one, voted to include the *Journal* in the provincial fee, requests have been received for permission to present the award to a preliminary student when she is capped. This pattern has been authorized and permission further extended for schools to apply for a one-year subscription for the best student in each class, where two classes are accepted in a year. As an alternative the student achieving highest standing in the theory and practice of nursing during her first year may be selected. This is proving to be a very popular method of presentation.



Miss Margaret Ann Wall of Hotel Dieu Hospital, Windsor, Ont., is shown receiving *The Canadian Nurse* award from Mrs. J. P. Kelly, registrar of the Windsor Nursing Registry. With them is Miss Frances Horvath who was second in line for the award.

The award is also open to the outstanding members of graduating classes from approved schools for psychiatric nurses and nursing assistants. In this instance, a one-year subscription is awarded annually to the graduate achieving the highest standing in the theory and practice of nursing.

To date this year, the award has been presented to 102 girls. Since its inception, 641 nurses or nursing assistants have been recipients. In this way, potential leaders in the nursing profession and its related branches are brought into early and close contact with their professional journal and, through this medium, with the aims, activities and accomplishments of their professional organizations.

## Ontario

The following are staff changes in the Ontario Public Health Nursing Services:

**Appointments** — *Hermance Buykes* (Wilhelmina Gasthuis, P.H. Nursing Amsterdam, Holland) to the London Dept. of P.H. *Kathleen Terrill* (Hamilton Gen. Hosp., Univ. of Toronto) to the Northumberland and Durham Health Unit. *Kathleen (Moore) MacGregor*, (Montreal Gen. Hosp. P.H. Nursing, McGill Univ.) to the Ottawa Board of Health. *Donna (McDonald) Southcott* (B.Sc.N., U. of T.) from the London Dept. of Health, to the Scarborough Township Board of Health. *Helen (Elliott) Kennedy*, (Hamilton Gen. Hosp., U. of T.) to the York Township B.H.

**Resignations** — *Mary (Lefave) Lindsay*, from the East York-Leaside H.U. *Ruth (Neilson) Roszell* from the London Dept. of Health. *Mary Ankcorn* from the Oshawa B. H. *Jessie (Renton) Campbell* from the Sault Ste. Marie B.H. *Arnoldina Petit* from the Toronto Dept. of P.H. *Noreen Heath* from the Windsor Dept. of Health.

## News Notes

### ALBERTA

#### DISTRICT 3

#### CALGARY

Rededication services held in May had a total attendance of 200 members. A special meeting of the chapter was called to discuss



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the proposed revision of bylaws prior to the annual provincial meeting. About 60 members attended the meeting with Miss A. Fallis, presiding.

### *General Hospital*

Miss F. Moore presented a report of the discussions and decisions proceeding from the annual provincial convention at a box-lunch supper meeting of chapter members. A 3-act play entitled "The Patient" followed the business session and illustrated the different fields of nursing involved in the care of one patient. The health and social agencies available to help a patient before, during and after surgery were highlighted.

### **DISTRICT 7**

#### **EDMONTON**

### *University of Alberta Hospital*

An "At Home" tea and sale of home baking initiated the year's activities of the alumnae association. A painting as a memorial to Miss Helen S. Peters was presented to the hospital and placed in the nurses' residence. Plans are underway for a rummage sale to be held in the fall.

### **STONY PLAIN**

Mrs. E. Lynes, a new member of the Health Unit, was welcomed to the chapter. M. Story represented the group at the Biennial Convention. Mrs. C. Robertson, one of the chapter members, has moved to Edmonton. Mrs. C. R. Wood, a member of the Alcoholism Foundation was guest speaker at one of the meetings. Members were invited to visit the Foundation. The film "A Day in the Life of a Cerebral Palsied Child" was shown on another occasion. In September a dinner meeting is planned that will be held in Edmonton.

### **BRITISH COLUMBIA**

#### **CHILLIWACK**

As a special project, chapter members conducted a drive to procure articles of clothing, cosmetics and jewelry which were donated to Essondale Mental Hospital. Miss J. Keith an exchange teacher to Australia showed slides and gave an interesting description of her experiences while in that country. Congratulations are in order for the all-nurse curling team skipped by E. Gibbons which once again won the trophy of the Business Girls Curling Club. Members elected to executive office for the cur-



rent year include I. Brown, pres.; E. Reid, sec.; K. Crowley, treas.

#### CRANBROOK

Dr. C. MacLean, director of Kootenay Travelling Clinic, addressed the members at a spring meeting. Mrs. C. Kram was the official delegate to the provincial meeting. Mrs. K. Johnson has returned after spending some time in Port Alberni.

#### SOUTH FRASER CHAPTER

##### LADNER

Forty-nine members and guests enjoyed a dinner meeting early in June. Among the guests were former bursary winners and their mothers. The annual bursary was presented this year to Doris Charlton, a student at the Royal Columbian Hospital.

Mr. P. Kinvig, a school principal and music consultant, presented an interesting program on music appreciation.

##### PENTICTON

Miss A. Houlton, C.A.R.S. representative, discussed "Physiotherapy Treatments" in the care of the patient with arthritis or rheumatism at a chapter meeting. Members of the Future Nurses' Club have attended a meeting as part of their program of orientation to nursing.

##### VANCOUVER

##### *St. Paul's Hospital*

The annual meeting of the alumnae association was held in June. Mrs. Collishaw presented a detailed report of the provincial meeting. Guest speakers at the convention were Professor N. A. Hall, School of Commerce, U.B.C., who discussed job analysis techniques as related to nursing, and Miss Pearl Stiver who described her trip to Turkey and, in her final address, spoke on "Togetherness" in the life of an organization. Plans are being made to hold a class reunion for the graduates of 1952 in September.

The dance in honor of this year's graduating class was both a social and financial success. F. McGeachie has completed a course in supervision in public health nursing at the University of Toronto. She is attached to Burnaby V.O.N. The class of 1925 held a reunion early in the year with 10 members present. Coming from a distance were Mrs. K. Wallace and Mrs. J. MacPherson.

##### VANCOUVER ISLAND

##### LADYSMITH

Dr. J. W. Neville opened the Florence Nightingale Tea in the spring. Mrs. H. Steele, president, convened the tea and welcomed the guests. A home cooking stall under the direction of Mrs. J. Mitchell and M. Tassin met with considerable success.

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**May 1957**

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Mrs. A. Quayle and Mrs. M. Duncan were in charge of a special "Kiddies Korner." The prevention, treatment and rehabilitation of poliomyelitis was ably demonstrated in a display prepared by H. Fulmore and L. Hamilton. A large number of nurses from this chapter attended the closing session of the provincial convention.

### WILLIAMS LAKE

Two current nursing and medical problems — *Staphylococcus aureus* infections and wood tick bites — were discussed at one of the regular chapter meetings. The research being to eliminate staphylococcal infections in one hospital was described by two public health nurses. The symptoms and treatment of wood tick bites were discussed by Mrs. Kaloor.

### MANITOBA

#### ST. BONIFACE

##### *St. Boniface Hospital*

Mrs. R. H. McNaughton, Sr. Superior Jarbeau, Sr. Clermont and Sr. Martel welcomed guests to the annual alumnae tea. A sale of home cooking, handicrafts and a raffle helped to swell the proceeds. The money obtained was used to increase the scholarship fund.

### WINNIPEG

#### *General Hospital*

Nearly 300 nurses attended the alumnae association dinner and dance in honor of the 1956 graduating class. During the evening a cheque for \$1,000 was presented to the hospital and accepted by Dr. Coppinger, superintendent, for use in furnishing the library of the new residence. This represented one-third of the amount pledged by the alumnae association. A roll call of classes revealed the presence of graduates of the early 1900's. Thirty members chose the occasion to celebrate their 25th anniversary and 40 graduates of 1946 enjoyed a reunion. The guest speaker was Rabbi Milton Aaron of Shaarey Zedek Synagogue. The toast to the graduating class was proposed by Dr. T. E. Cuddy and was responded to by T. Skagfjord.

The new graduates were also honored at a reception held in Government House. Miss M. E. Cameron, director of the school of nursing, received with Mrs. J. S. McDiarmid, chataleine of Government House. Lt.-Commander L. E. Avery and A. W. Everett, aides-de-camp to His Honor the Lieutenant-Governor, were in attendance. The climax of graduation activities was reached with the exercises held in Knox United Church. J. Burton Thomas, Dean of Rupertsland was the guest speaker.

Miss Isabel Stewart, Professor Emeritus



of Nursing Education, Teachers College, Columbia University opened a tea and sale of work sponsored by the alumnae association. She later addressed a special meeting on "The Future of Nursing."

## NEW BRUNSWICK

### SAINT JOHN

Members of the local chapter will be hostesses for the annual provincial meeting in October. A short play "For Those who Follow" was enacted at one of the regular meetings illustrating some of the general ideas held by the public on the subject of tuberculosis and emphasizing the importance of public education. D. Byers presented a general outline of projected plans for student affiliation in tuberculosis. Miss L. Smith, vice-president of the N.B.A.R.N. was a special guest on this same occasion. Miss Hoosier was named official delegate to the Biennial Convention in June.

### General Hospital

A life membership in the alumnae association was conferred upon S. Wetmore for her invaluable leadership of the committee that assembled a history of the hospital and school of nursing. This text is now ready for sale with M. Moore in charge of distribution. Many friends of the school of nursing attended the ceremony which opened the new wing of the nurses' residence. The president and board of commissioners sponsored a reception in honor of the new graduates of 1956 following their graduation ceremony.

### Saint Joseph's Hospital

Dr. T. E. Grant addressed the graduating class on the occasion of their graduation ceremony. The valedictory was given by Nancy Wedge. Diplomas were presented by Rev. A. B. Leverman, Bishop of Saint John. Prize winners included N. Wedge, highest in theory and medical nursing; E. McNeil, general proficiency; D. Joseph, Christian doctrine; P. Ballard, medical ethics; H. Denny, professional ethics. Sarah B. McNeil received her Bachelor of Science in Nursing from St. Thomas University, Chatham. N. Belliveau has joined the staff.

## ONTARIO

### DISTRICT 2

### WOODSTOCK

Approximately 100 members attended the spring meeting of the district held in Woodstock. Mrs. J. D. Taylor addressed the members at the afternoon session on the aims of adult education. Mrs. A. Jameson, guest speaker of the evening, chose as her topic "The Key Men of Asia" and described present Asiatic political conditions. A donation of \$25.00 was forwarded to the Greek Red Cross Society.

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To take place on October 17, 18 and 19, 1956 at Halifax, Yarmouth, Amherst, Sydney and New Glasgow. Requests for application forms should be made at once and forms **MUST BE** returned to the Registered Nurses' Association of Nova Scotia **not later than September 17, 1956**, together with:—

- (1) *Diploma of School of Nursing*
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No undergraduate may write unless he or she has passed successfully all final School of Nursing examinations and is within six (6) weeks of completion of the course of Nursing.

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**DISTRICT 3**

**KITCHENER**

*Kitchener-Waterloo Hospital*

Miss Helen G. McArthur was the guest speaker at the graduation exercises held in mid-June. Fourteen new graduates received their diplomas and pins from Miss Rahno Beamish, director of nursing and Dr. Deborah Glaister, school physician. N. Reist received the award for general proficiency, G. Bickle obtained the prize for highest standing in theory and M. Roblin won highest honors in tuberculosis nursing and also received *The Canadian Nurse* award for professional development. The valedictory address was given by K. Pauls.

**DISTRICT 4**

**HAMILTON**

*General Hospital*

Mrs. Mary Evenden, a teacher from the Easthaven School for Retarded Children gave a most interesting account of the activities of the school at a recent alumnae meeting. Colored slides illustrated her remarks most effectively. W. Pinkney gave an able summary of her activities as official delegate to the R.N.A.O. annual convention. Of interest to alumnae members and other

graduates is the announcement that "The History of the Hamilton General Hospital School of Nursing" prepared by Mrs. Marjorie F. Campbell is now available for sale.

Early in June the graduating class of 1956 and their mothers were guests of honor at a "Mother and Daughter Tea" held in the nurses' residence. Graduation exercises were held in the Temple Building of the Scottish Rite Club with Dr. W. J. Deadman as guest speaker. Dr. Deadman retired this year from his position as Director of Laboratories and city pathologist after 42 years of invaluable service. Pins and diplomas were presented to the graduates by Miss G. Watson, a graduate of 1894.

**DISTRICT 5**

**TORONTO**

*Hospital for Sick Children*

Members of the graduating class and their mothers were guests of honor of the alumnae association at a tea early in June. Mrs. C. I. Junkin, Miss J. Masten, director of nurses, Miss M. Gibson and Miss Waddell received the guests. Plans are progressing for the annual Christmas luncheon to be held early in December. Out-of-town members are assisting in this project by contributing hand-made articles and other gifts as well as cash donations.

*St. Michael's Hospital*

M. Dunlop and L. McCusker have joined the staff of the Vancouver General Hospital. E. Barrett is working in St. Vincent's Hospital, Vancouver. M. Hartibese is the nursing arts instructor at St. Mary's Hospital, Timmins. C. Maddaford is Regional Director of the Northern Area with the V.O.N.A. Metzler, who is a matron of the R.C.A.M.C., attended the University of Alberta, Edmonton this year. M. Pallett is the matron at the Army hospital, Shilo, Man. J. Paloschuk is on the staff of Harper Hospital, Detroit. M. Godin has joined the staff of the Ottawa Public Health Department after successfully completing her public health nursing course at the University of Ottawa.

*University of Toronto  
School of Nursing*

"Fatigue in Women" was the subject chosen for an address by Dr. Marion Hiliard at a meeting of the alumnae association early in the year. A large number gathered in Cody Hall to hear this very dynamic speaker. At a subsequent meeting members were made aware of their responsibilities for promotion of mental health as Dr. R. Gerstein outlined them in "Mental Health — A Challenge in Nursing." A successful theatre night improved the financial standing of the association substantially under the capable direction of Mrs. S. Morris and Mrs. S. Stephens. The graduating class of 1956 enjoyed a tea given in

their honor as part of graduation festivities.

## DISTRICT 8

### OTTAWA

#### *General Hospital*

A memorial service was held in the chapel early in May. Members of the alumnae executive were hostesses at a tea held early in June in honor of M. T. Belliveau, a past president of the association. Miss Belliveau was presented with a gift in appreciation of her work.

#### *Lady Stanley Institute*

The annual meeting of the alumnae association was held at The Royal Ottawa Sanatorium. Mrs. C. H. Port gave an interesting report regarding her work on "The Book of Remembrance."

#### *St. Luke's Hospital*

Members of the alumnae association enjoyed an interesting program at their annual dinner early in June.

## DISTRICT 12

### KIRKLAND LAKE

Over 70 nurses attended the fifth annual meeting of this district representing Tri-town, Porcupine, Northland and Kirkland Lake. Members were welcomed by Reeve H. Cooper, Dr. J. S. Jamieson of the local Medical Society and Miss E. Irwin, Chapter president.

Mrs. G. Loosemore, district president, emphasized the need for examination of our attitude towards nursing to determine if everything possible is being done to bring about its advancement. The guest speaker Miss M. Pearl Stiver, was introduced by Miss S. Coutts, matron of the Kapuskasing hospital. Miss Stiver discussed the factors affecting nursing suggested by the monogram, "C.N.A. — construction, nurses, aims and activities."

## PRINCE EDWARD ISLAND

### CHARLOTTETOWN

A three-day institute sponsored by the district association provided interested nurses with an opportunity to hear about and see techniques of nursing in maternal and child health. Lectures and demonstrations were given under the direction of Miss B. Rowland, Nursing Consultant with the Department of Health. The effect on nursing of modern developments in drug therapy was the subject of a panel discussion led by Sr. M. Patricia, surgical nursing supervisor of the Charlottetown Hospital. The significance of staphylococcal infections in general hospitals was the subject of a joint address by Dr. H. Shaw, Director of Medical Laboratories, and F. W. Jelks, Ph.D., provincial bacteriologist.

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The provincial association of nurses announced the adoption of the National League for Nursing Evaluation Service. State Board Test Pool Examinations were used for the first time in July.

The care of the mother during the pre-natal period and of the infant immediately following birth was demonstrated and discussed intensively at a four-day refresher course directed by Miss Esther Robertson, Nursing Consultant, Dept. of National Health and Welfare and Miss B. Rowland. Public health nurses and instructors from all hospitals attended. Topics ranged from nursing responsibilities in regard to family health counselling through preparation for

childbearing and delivery to health supervision and teaching opportunities. A number of films were shown which added even more interest to the well organized and planned program.

## Prince Edward Island Hospital

The 63rd graduation ceremony was held in The Prince of Wales College Auditorium. Twenty girls received their pins and diplomas from Mrs. Lois MacDonald, superintendent of nurses, and His Honor, Lieutenant Governor T. W. L. Prowse. Dr. J. W. MacKenzie presided and the address to the members of the graduating class was given



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Further information may be obtained from:

Miss Phyllis J. Lyttle, R.N.  
Superintendent of Nurses  
Department of Public Health  
Box 488, Halifax, Nova Scotia

Application forms may be obtained from the

### NOVA SCOTIA CIVIL SERVICE COMMISSION

P.O. Box 943, Provincial Administration  
Building, Halifax, Nova Scotia

or  
by telephoning 2-7341 - Branch 230

by Dr. E. S. Giddings. The valedictory was delivered by Miss H. Cameron.

A dance sponsored by the alumnae of the hospital was held as part of graduation festivities. Medical and nursing staff, student nurses and friends enjoyed a delightful evening.

## QUEBEC

### DISTRICT 9

## QUEBEC CITY

### *Jeffery Hale's Hospital*

The spring class of student nurses received their caps at a pleasant ceremony in May. D. MacLeod was the recipient of *The Canadian Nurse* award. Miss M. Jamieson, director of nurses, addressed the group, choosing as her topic "Nursing Yesterday and Today." Premier Duplessis officially opened the new hospital at a ceremony held on the grounds early in the year.

### DISTRICT 11

## MONTREAL

Pamela E. Poole, Queen Elizabeth Hospital, Sr. Ste. Marguerite M. Alacque, Hotel-Dieu de Gaspé and Marie Claire

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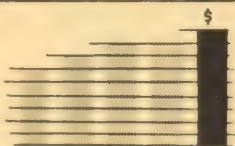
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59th Street West,  
New York City**

Beaudoin, Notre-Dame de l'Esperance have been awarded provincial bursaries for advanced university study.

## *Royal Victoria Hospital*

Miss Grace A. K. Moffat has been made a life member of the alumnae association. The announcement was made at the recent annual meeting. Hamilton chapter held a tea at the home of M. Schwartz with an attendance of 17 alumnae. Fredericton members enjoyed a buffet supper at the home of O. (Ellis) McCombe. There were 42 graduates present. E. MacLennan brought greetings from the Nova Scotia chapters. G. (Parlee) Sinclair is secretary of the Saint John group while G. Abrams has been elected president of the Moncton chapter.

J. Stalker is a supervisor at the Cancer Institute, Lima, Peru. L. Gaulton is with the Department of Child and Infant Welfare, Saint John. M. (Wainwright) Hoffman, G. (Wainwright) Bliss and L. A. (Wells) Burnfield have been recent visitors.

## *St. Mary's Hospital*

The Gertrude McLellan Fund has been organized by members of the alumnae association. The purpose of the fund is to provide assistance to student nurses of the hospital. Members elected to office for the current year include: Mrs. K. Mooney, pres.; H. Murphy, treas.; Mrs. T. Bier-nacki, corr. sec.; J. McLellan, rec. sec.

## **SASKATCHEWAN**

### **SASKATOON**

#### *City Hospital*

Members of the graduating class of 1956 were entertained at a court whist party by the alumnae association early in the year. Two members of the medical staff, Dr. Dale and Dr. Burke assisted with entertainment which included a singsong.

At a regular meeting of the association in May, Miss Hazel Keeler of the University Hospital attended as guest speaker. Her description of her tour of western Europe and her collection of slides were enjoyed by all.

#### *St. Paul's Hospital*

Graduation exercises for the largest class ever to convocate from the school of nursing were held in mid-May. Seventy-three nurses received their diplomas from Rev. R. W. Finn, professor of philosophy, St. Thomas More College, University of Saskatchewan. Dean J. F. Leddy of the Faculty of Arts and Science presented the awards. Miss M. Mackenzie, clinical coordinator, administered the nurses' pledge. The address to the graduating class was given by Dr. D. M. Baltzan, chief of staff of the hospital. The school of nursing glee club under the direction of J. Shewchuk participated in the ceremony with J. McKerrow as accompanist.

# Employment Opportunities

ADVERTISING RATES — \$5.00 for 3 lines or less; \$1.00 for each additional line.

U.S.A. & Foreign — \$7.50 for 3 lines or less; \$1.50 for each additional line.

Closing date for copy and cancellations: 10th of the month preceding the month of publication. All letters should be addressed to: The Canadian Nurse, 1522 Sherbrooke St. W., Montreal 25, Que.

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**Superintendent of Nurses (1).** Salary: \$275 per mo. **Graduate Nurses (2).** Salary: \$225 per mo. less \$40 per mo. room, board & laundry. 28-bed hospital, pleasant surroundings, 5 mi. from U.S. border. 40-hr. wk., 4 wk. vacation after 1 yr. service. 1½ days sick leave per mo., yearly accumulative. Nice nurses' residence. Apply The Grands Forks Community Hospital, Grand Forks, B.C.

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**Registered Nurses (2) for modern 8-bed hospital immediately.** Salary: \$240 per mo. Full maintenance \$30 per mo. Apply B.E.I. Magnusson Box 11, Hodgeville Saskatchewan

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**Superintendent of Nurses (Immediately), Operating Room Supervisor & General Duty Nurses** for new 80-bed hospital opening August, 1956. Postgraduate with experience preferred. Apply Administrator, Portage la Prairie, Manitoba.

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**Superintendent of Nurses for 53-bed hospital.** Fully accredited & offering ideal working conditions to a qualified Registered Nurse. Salary: \$225 plus full maintenance & apt. in new nurses' residence. Excellent personnel policies. 1 mo. annual vacation. Apply Secretary, Kentville Hospital Assoc., Kentville, Nova Scotia.

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**Superintendent (Sept. 1, 1956 or before) for modern 50-bed Community Hospital, 50 mi. from Ottawa.** Full maintenance. 1 mo. vacation with pay after 1 yr. service. 7 statutory holidays. Apply stating qualifications & references to Sec. to the Board, Pontiac Community Hospital, Shawville, Que.

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**Matron & General Duty Nurse for 8-bed hospital.** Salaries: \$265 & \$235 gross with 6, \$5.00 increases every 6 mo. \$25 maintenance in separate nurses' residence. 8-hr. shifts. 1 mo. vacation. Sick leave. Apply Sec. Treas., Kyle-White Bear Union Hospital, Kyle, Sask.

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**Matron (1) \$230 per mo. General Duty Nurses (2), \$200 per mo., with full maintenance for 20-bed hospital.** Modern nurses' home. Usual holidays with pay & sick leave etc. Apply to Matron, Union Hospital, Vanguard, Sask.

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**Asst. Director of Nursing for 450-bed hospital with school of nursing.** Experienced, preferably with University Certificate of postgraduate training. Salary according to experience. 40-hr. wk. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

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**Night Supervisor, Head Nurse, Assistant Head Nurse & General Duty Nurses for 156-bed Pediatric Hospital.** Rotating shifts for staff nurses. Student nurse affiliation program in Orthopedic-Pediatric nursing. Apply Director of Nursing Alberta Red Cross Crippled Children's Hospital, Calgary, Alta.

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**Pediatric Supervisor (Experienced with postgraduate study) for supervision of Children's Ward & Nursery in 100-bed hospital.** Apply Director of Nurses, Royal Alexandra Hospital Edmonton, Alberta.

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**Supervisor for Pediatrics Dept.** with postgraduate course or equivalent. Contract conforms with R.N.A.B.C. personnel practices. Apply Director of Nurses, General Hospital Chilliwack, B.C.

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**Supervisor (Experienced)** to act as Assistant Superintendent in a general supervisory position in active 50-bed hospital near Toronto. Apply giving full information as to qualifications, experience & references to Supt., General Hospital, Cobourg, Ont.

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**Operating Room Supervisor, Night Supervisor & Staff Nurses.** Good salary & personnel policies. Living accommodations available. Apply Director of Nurses, General Hospital, Parry Sound, Ontario.

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**Night Supervisor, Assistant Head Nurses & Staff Nurses.** Excellent personnel policies. Apply Director, Shriner's Hospital for Crippled Children, 1529 Cedar Ave., Montreal, Que.

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**Operating Room Supervisor — Dynamic & ambitious for 325-bed, private non-profit, fully air-conditioned Medical Center in mid-west university city.** Excellent salary & personnel policies. Give full details of education & experience in first letter. Apply Box #C, The Canadian Nurse Journal, 1522 Sherbrooke St. W., Montreal, Que.



**Operating Room Supervisor.** Qualified by experience or postgraduate training for August or September in preparation to taking charge of Operating Room October 1st. For full particulars apply Director of Nurses, Union Hospital, Swift Current, Sask.

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**McKellar General Hospital, Fort William, Ont. requires Registered General Duty Nurses.** Good personnel policies. Residence accommodation available at reasonable rates. Hospital has recently completed a well equipped & staffed wing with extensive renovation program progressing in the old section. Apply Director of Nursing.

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**Instructor in science (1) & medical-surgical (1) for Aug.** Excellent personnel policies. Apply Director of Nurses, St. Joseph's Hospital, North Bay, Ontario.

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**Surgical (1) & Pediatric (1) Instructors** for 300-bed hospital with school of nursing at Head of the Lakes. Salary based on R.N.A.O. recommendations. 1 mo. vacation after 1 yr. service. Attractive living accommodation available. Apply, stating experience & date available, to Director of Nursing, General Hospital, Port Arthur, Ont.

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**Instructor for school of nursing** — Applications are invited for 138-bed hospital. This school is affiliated with Montreal hospitals, the teaching schools associated with McGill University. For particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

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**Registered Nurses (2) for 18-bed General Hospital, situated on the beautiful Arrow Lakes.** B.C. standard salaries. Holidays. 40-hr. wk. Apply Matron, Arrow Lakes Hospital, Nakusp, B.C.

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**Registered General Staff Nurses** for 30-bed hospital. \$225 plus \$10 if B.C. Reg'd. 40-hr. wk., 10 paid statutory holidays, 4 wk. vacation, residence accommodation. Apply Administrator, Ladysmith General Hospital, Vancouver Island, B.C.

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**Registered General Duty Nurse** for fully modern 30-bed hospital. Gross starting salary \$210 per mo. increased according to experience, with salary increases of \$5.00 after each 6 mo. service. Overtime. 4 wk. vacation with pay after 1 yr. service. 44-hr. wk. All statutory holidays. Accumulative sick leave. Separate living quarters. Apply Superintendent, District Hospital, Roblin, Man.

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**Registered Nurses for new 65-bed hospital, 25 mi. north of Winnipeg.** Hourly bus service. Salary: \$195-215. \$10 differential for evening & night duty. Accommodation available in new residence with T.V. Usual personnel policies. Apply Supt. General Hospital, Selkirk, Manitoba.

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**Registered Nurses.** Single room residence. \$225 per mo. gross. 5 day wk. 20 mi. east of Toronto. Apply Supt. Ajax & Pickering General Hospital, Ajax, Ont.

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**Registered Nurses.** Gross salary for nurses currently registered in Ont. \$235 per mo. Good personnel policies. New facilities. Comfortable nurses' residence. 8-hr. rotating shift. 44-hr. wk. 1 day off 1 wk., 2 the next. 1½ days holiday allowed per mo. same sick time accumulated to 90 days. 8 legal holidays per yr. The equivalent of single train fare paid up to \$40 after 1 yr. service. Apply Supt., Lady Minto Hospital, Cochrane, Ont.

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**Registered General Duty Nurses** for new 58-bed hospital situated in North Western Ontario. Opening about Sept. 1, 1956. Salary: \$227 per mo. subject to increase after 6-mo. with regular annual increase thereafter. \$45 per mo. room & board. 30 days vacation & rail fare refunded after 1 yr. service. New 21-bed nurses' residence each room having an adjoining bathroom. Apply stating age & when available to Frederick Taylor, Administrator, Dist. General Hospital, Dryden, Ont.

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**Registered Nurses for General Duty.** Initial salary: \$200 per mo.; with 6 or more months Psychiatric experience, \$210 per mo. Salary increase at end of 1 yr. 44-hr. wk.; 8 statutory holidays, annual vacation with pay. Living accommodation if desired. For further information apply Supt. of Nurses, Homewood Sanitarium, Guelph, Ont.

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**Registered General Duty Nurses for 200-bed hospital in the Niagara Peninsula.** Gross salary \$210, afternoons — \$220, nights — \$215. Annual increments. 44-hr. wk. 3-wk. vacation per yr., 8 statutory holidays. Cumulative sick leave. Accommodation available in attractive residence. Apply Director of Nursing, County General Hospital, Welland Ont.

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**Reg'd. Nurses for modern 60-bed General Hospital situated 40 mi. south of Montreal.** Salary: \$200 per mo., additional monthly bonus for permanent evening & night shifts. 44-hr. wk., 8-hr. duty. Many attractive benefits provided. Board & accommodation available at minimum cost in completely new motel-style nurses' residence. Apply Supt., Barrie Memorial Hospital, Ormstown, Que.

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**Registered Staff Nurses (Immediately) for 220-bed hospital, including new finely equipped wing.** Duty assignments in Obstetrical, Medical & Surgical Units. Gross starting salary: \$220. Good personnel policies. Paid vacations, sick leave, pension plan. Apply Director of Nursing Union Hospital, Moose Jaw, Sask.

**Registered Nurses for 82-bed accredited hospital.** Gross salary \$210-\$230 per mo. 5½ day wk. with no split shifts. 30 days vacation with pay after 1 yr. service. Statutory holidays. Room in comfortable residence & laundry of uniforms provided at \$8.00 to \$12 per mo. Apply Supt. of Nurses, Union Hospital, Canora, Sask.

**Registered Nurses. Male & Female.** Starting salary: \$300 up, plus \$10 pm shifts. 40-hr. wk., paid vacation, 10 days sick leave. Social Security, hospital group ins. Apply Mr. Glenn A. Dickau, R.N., Administrator, Memorial Hospital, Corning, California.

**Registered Nurses (under age 50) General Duty — \$330 per mo. Head Nurse — \$345 to \$360 per mo.** Evening & night differentials. Retirement plan, sick leave benefits. 3 wk. vacation, 11 holidays. Modern nurses' residences. State eligibility for California registration & submit photo to Director of Nurses, Tulare-Kings Counties Hospital, Springville, California.

**Registered General Duty Nurses for 118-bed General Hospital** along the shores of Lake Michigan, 25 mi. from Chicago. Base salary: \$300. Additional differential of \$30 for evenings & \$20 for nights. 5 day wk. Good personnel policies. Apply Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

**Registered Nurses for Medical-Surgical, Psychiatric, Obstetrical & Pediatric Units. 325-bed, air-conditioned hospital.** Starting salary: \$265 with bonus for evening & night duty 40-hr. wk. Liberal personnel policies, low cost cafeteria, free laundry. Apply Director of Nursing, Menorah Medical Center, 4949 Rockhill Rd., Kansas City, Missouri.

**Registered Nurses for 398-bed J.C.A.H. non-sectarian research & teaching hospital with N.L.N. fully accredited school of nursing.** Liberal personnel policies include tuition aid for study at Western Reserve University. Housing available at reasonable rates. Apply Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th St., Cleveland 6, Ohio.

**Registered Nurses for 284-bed General Hospital** with vacancies in most departments including Psychiatry. Opportunity for advancement. Located on the beautiful Corpus Christi Bay in Texas which is a pleasant tropical climate. Positions available for (1) **Supervisors**, salary: \$280-\$315 per mo. (2) **General Staff**, starting salary: \$250-\$275 according to experience plus \$10 differential for evening or night shifts. Liberal personnel policies, 40-hr. wk. & \$50 transportation allowance. Apply Director of Nursing Service, Memorial Hospital, P.O. Box 5008, Corpus Christi, Texas.

**Registered Nurses for General Duty Staff.** Salary commences at £40-10-0 per mo. with full maintenance. Transportation allowance. For full particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

**General Duty Nurses (3) immediately for 30-bed hospital.** Located in a good town 80 mi. east of Calgary on the CPR main line & the Trans Canada Highway. Salary: \$170 per mo. with full maintenance. Increases every 6 mo. 48-hr. wk. 8-hr. rotating shift. Apply by letter or wire for details of our staff plan to Mrs. H. Hislop, Matron, Municipal Hospital, Bassano, Alta.

**General Duty Nurses (Immediately) for 50-bed hospital on Edmonton-Calgary highway.** Starting salary, without experience: \$175 per mo. with full maintenance & laundry. Increment for experience. Semi-annual increases. 3-wk. vacation plus 10 statutory holidays after 1 yr. 1½ days sick leave per mo. Voluntary pension plan. 50% Blue Cross Premiums. Apply, giving full particulars & date available to Matron, Municipal Hospital, Ponoka, Alberta.

**General Duty Nurses (2), Operating Room Nurse (1) for 70-bed hospital.** Starting salary: \$222 with increments. 40-hr. wk., 28 days vacation plus 10 statutory holidays. 1½ days sick leave monthly. Fare from Vancouver paid after 6 mo. & full board deduction of \$25. Apply Matron, St. George's Hospital, Alert Bay, B.C.

**General Duty Nurses for 110-bed General Hospital** situated in the beautiful Fraser Valley, 68 mi. from Vancouver. Good bus service. Salary: \$230 per mo. Personnel policies in accordance with R.N.A.B.C. agreement. 40-hr. wk. Residence accommodation. Apply Director of Nursing, General Hospital, Chilliwack, B.C.

**General Duty Nurses.** Salary: \$230-270, \$10 increment for experience. 40-hr. wk. 1½ days sick leave per mo. cumulative; 10 statutory holidays 1 mo. vacation. Must be eligible for B.C. registration. Apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

**General Duty Nurses (3) Immediately for 27-bed Community Hospital.** Salary: \$230 per mo. with annual increments of \$5.00 per mo. 40-hr. wk. 28 days vacation after 1 yr. service. All statutory holidays paid. Room, board & laundry \$40 per mo. Apply, giving full details, Matron, Slocan Community Hospital, New Denver, B.C.

**General Duty Nurses** for 430-bed hospital; 40-hr. wk. Statutory holidays. Salary \$235-268. Credit for past experience. Annual increments; cumulative sick leave; 28 days annual vacation; B.C. registration required. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

**Royal Jubilee Hospital, Victoria, B.C.** invites applications for **General Duty Nurses** for permanent positions & vacation relief in 500-bed General Hospital. Salary \$227.50-\$262.50 5-day, 40-hr. wk. 4-wk vacation. 10 statutory holidays. Pension plan. Attractive employee benefits. Apply, Director of Nursing.

**General Duty Nurses for Medical, Surgical, Pediatrics, Obstetrics.** Good salary & personnel policies. Apply Director of Nursing, Victoria Hospital, London, Ont.

**General Duty Nurses** for all departments. Gross salary: \$210 per mo. if registered in Ontario \$200 per mo. until registration has been established. \$20 per mo. bonus for evening or night duty; annual increment of \$10 per mo. for 3 yrs. 44-hr. wk., 8 statutory holidays, 21 days vacation & 14 days leave for illness with pay after 1 yr. of employment. Apply: Director of Nursing, General Hospital, Oshawa, Ont.

**General Duty Nurses (3), O.R. Scrub Nurse** for new 143-adult bed plus 30-bassinette hospital. Good personnel policies. Starting salary: \$215 per mo. Apply Director of Nurses, Plummer Memorial Hosp., Sault Ste. Marie, Ontario.

**General Duty Nurses** for 650-bed teaching hospital in central California. Salary: \$288-\$337 per mo. 40-hr. wk. Liberal vacation, holiday & sick leave plan. Apply Personnel Office, 510 E. Market St., Stockton, California.

**Graduate Nurses (3)** for 24-bed hospital. Salary: \$230 per mo. if B.C. registered; less \$40 board, lodging, laundry. 1 mo. vacation after 1 yr. on full pay. 1½ days sick leave per mo. cumulative. Apply, stating experience to Matron, Terrace & District Hospital, Terrace, British Columbia.

**Graduate Nurses (General Staff Positions)** for General Hospital. Salary: \$235.50 per mo. as minimum & \$273.75 as maximum, plus shift differential for evening & night duty, 40-hr. wk. Temporary residence accommodation is available. Applicants not registered in B.C. should forward a letter of acceptance of registration in B.C. from the Registrar of Nurses, 2524 Cypress St., Vancouver, B.C. Please apply Personnel Dept., Vancouver General Hospital, Vancouver, B.C.

**Graduate Nurses & Dietician (1)** for new, very modern 88-bed hospital in a pleasant progressive town. Nurses salary: \$200 per mo. Annual increase \$10 per mo. for 3 yrs. 2-wk. shift rotation, bonus for night shifts, 1 hr. drive to Toronto & several resorts. Local swimming pool, bowling alleys, skating, theatres etc. Apply Director of Nurses, Dufferin Area Hospital, Orangeville, Ont.

**Graduate Nurse for 6-bed clinical investigation unit, (Rotating Service.)** Excellent opportunities to gain experience in research unit specializing in nutritional & metabolic diseases of infants & children. Applications invited from graduates of Canadian, United States or overseas hospitals. Apply Director of Nursing, Hospital for Sick Children, Toronto 2, Ont.

**Graduate Nurses** for duty on Obstetrical, Medical & Surgical Wards. Personnel policies as recommended by the Assoc. of Nurses of the Prov. of Quebec. Please apply Director of Nursing, Queen Elizabeth Hospital of Montreal 2100 Marlowe Ave., Montreal 28, Que.

**Graduate Nurses for Psychiatric & General Duty at Wayne County Gen. Hospital & Infirmary, Eljose, Mich.,** located 17 mi. from downtown Detroit. Salary range: \$4,360-\$4,840, 40-hr. wk. Some 48-hr. positions open at \$5,668-\$6,292. Liberal vacation & sick leave. Candidates must be graduates of accredited Canadian nursing schools. Visa required. For information apply Wayne County Civil Service Commission, 628 City-County Bldg., Detroit 26, Michigan.

**Graduate Nurses** for new modern equipped hospital. Pleasant working conditions. Salary \$260 per mo. Liberal vacation & health benefits. Meal on duty. Write, telephone or telegraph at our expense to Memorial Hospital, Cut Bank, Montana.

**General Staff Nurses** for 400-bed Medical & Surgical Sanatorium, fully approved student affiliation & postgraduate program. Full maintenance. Recreational facilities. Vacation with pay. Sick benefits after 1 yr. Blue Cross coverage. Attractive salary; 40-hr. wk. For further particulars apply Supt. of Nurses, Nova Scotia Sanatorium, Kentville, N.S.

**Staff Nurses for 500-bed General Hospital.** Beginning salary: \$300 per mo. with advancement to \$335 for those eligible for registration in the state of Michigan. Additional differential \$1.50 per afternoon or night. 40-hr. wk. Hospital & school of nursing fully approved. Apply Director of Nursing, The Grace Hospital, 4160 John R. St., Detroit 1, Michigan.

**Staff Nurses for 600-bed General & Tuberculosis Hospitals with student programs.** In central valley, city of 108,000. State & Junior Colleges afford opportunity for advanced education. Salary \$300 with 4 annual increases to \$341. Full maintenance \$45 per mo. Liberal personnel policies. Apply Assoc. Director of Nursing Service, County General Hospital, Fresno, California.



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requires

EXPERIENCED PUBLIC HEALTH NURSES

**GOOD SALARY RANGE**

and

**PERSONNEL POLICIES**

*For further information apply to:*

**THE SUPERVISOR OF NURSING SERVICES,  
ONTARIO SOCIETY FOR CRIPPLED CHILDREN,  
92 COLLEGE STREET, TORONTO 2, ONTARIO**

**General Staff Nurses (all departments)** for 340-bed hospital conveniently located near New York City. Beginning salary: \$260 per mo. \$30 bonus for 2:30-11 P.M. \$20 for 10:30 P.M.-7 A.M. Extra bonus for Operating & Delivery rooms. Increments every 6 mo. for 5 yrs. 40-hr. 5-day wk. 1 meal & laundering of uniforms gratis. Living quarters available at moderate cost. Excellent personnel policies. Overtime pay. 4 wk. vacation after 1 yr. 8 paid holidays. Sick time cumulative to 60 days. In-Staff educational program. Blue Cross ins. Pleasant working surroundings. Apply Director of Nursing Service, Presbyterian Hospital, Newark, New Jersey.

**Operating Room Nurse (1). General Duty Nurses** to increase staff. Salary \$235 per mo for B.C. Registration. R.N.A.B.C. personnel policies. 40-hr. wk. Apply Acting Director of Nurses, General Hospital, Nanaimo, British Columbia.

Excellent opportunities in **Private Nursing** are available in Bermuda. Rates similar to those in effect in Province of Quebec. For information regarding openings write to Matron, King Edward VII Memorial Hospital, Bermuda.

**Laboratory Technician (September 1st.)** for 70-bed hospital. Starting salary: \$222 with increments. 40-hr. wk., 28 days vacation plus 10 statutory holidays. 1½ days sick leave monthly. Fare from Vancouver paid after 6 mo. & full board deduction of 25. Apply Administrator, St. George's Hospital, Alert Bay, B.C.

**Nurse Technician (Immediately)** preferably trained for intravenous therapy transfusions etc. Apply Asst. Supt., Civic Hospital, Ottawa, Ontario.

**Registered or Licensed Practical Nurse.** Starting salary: \$175 per mo. for R.N. \$110 for practical. Full maintenance & living-in privileges included. 5 annual increments of \$5.00 per mo. Apply John Hiscock, Sec.-Treas., Baldur Medical Nursing Unit, Baldur, Man.

**Office Nurse for Two-Doctor Practice.** Should be able to do ordinary laboratory work. No reception duties or evening work. Salary: \$175 to \$250 per month depending on ability & experience. Apply C. R. Cousineau & G. E. Foster M.D., Castor, Alberta.

**Public Health Nurses (Qualified)** for City of Oshawa. 4 vacancies. Generalized program in urban area. Starting salary without experience \$3,100. Annual increment \$120. Transportation provided. 5-day wk. Pension & hospitalization plans available. Apply A. F. Mackay M.D., Medical Officer of Health, City Hall, Oshawa, Ont.

## NURSE TECHNICIANS

A new comprehensive 2-year course of training in the Radiotherapy Dept., starts this September. Graduate Nurses (Senior Matriculation with physics) are invited to make enquiries into this interesting sphere which utilizes both nursing & technical skill.

Satisfactorily scaled remuneration is received during the 2 yrs. & a staff position is assured on qualification.

**WRITE OR PHONE MRS. B. SHIFFMAN, SEC., FOR TRAINING, DEPT., OF RADIOTHERAPY,  
TORONTO GENERAL HOSPITAL, TORONTO. EMPIRE 6-2957.**



## DIRECTOR OF NURSING

Fully accredited suburban hospital recently enlarged to 125 beds requires Director to take charge of Nursing Service of 110 personnel — No training school.

- Postgraduate training in Nursing Administration &/or equivalent experience required.
- Salary fully commensurate with the importance of the position.
- Full scope for progressive direction & personal satisfaction.
- Congenial working conditions in a well established smaller city hospital.

Enquire in confidence to

Administrator: HUMBER MEMORIAL HOSPITAL, 200 CHURCH ST., WESTON, TORONTO 15, ONT.

**Public Health Nurses.** Duties to commence between June & Sept. 1956. Salary: \$2,796-\$3,396. 5-day wk. 1 mo. vacation. Pension plan. Apply Dr. W. H. Hill, M.O.H., Dept. of Health, Calgary, Alta.

**Staff Nurses Grade 1 for Provincial Mental Hospital.** Permanent positions & summer relief work. Salary: \$239 to \$271 per mo. Must be a reg'd. nurse currently registered in B.C. or eligible for registration in the province. Preferably some experience in general nursing. Applicants must be British subjects. For further information & application forms apply Personnel Officer, Civil Service Commission, Essondale, B.C. Phone, L.A. 1-1911.

**Public Health Nurse Grade 1.** British Columbia Civil Service, Dept. of Health & Welfare. Starting Salary \$255, \$260, \$266 per mo., depending on experience, rising to \$298. per mo. Promotional opportunities available. Qualifications: Candidate must be eligible for registration in British Columbia & have completed a University degree or Certificate course in Public Health Nursing. (Successful candidates may be required to serve in any part of the Province.) Cars are provided. 5-day wk. in most districts. Uniform allowance. Candidates must be British subjects; preference is given to ex-service women. Application forms obtainable from all Government Agencies, the Civil Service Commission, 544 Michigan St., Victoria, or 411 Dunsmuir St., Vancouver 3, to be completed & returned to the Chairman, Civil Service Commission, Victoria. Further information may be obtained from the Director, Public Health Nursing, Dept. of Health & Welfare, Parliament Bldgs., Victoria, B.C.

**Public Health Nurses (qualified) for generalized program.** Salary \$2,700 to \$3,200 depending on experience. Annual increment \$100. 5-day wk. Pension plan. Blue Cross & P.S.I. available. Car provided or car allowance. Apply Dr. Charlotte M. Horner, Director, Northumberland-Durham Health Unit, Cobourg, Ont.

**Public Health Staff Nurses (2) for generalized program** in city of 43,000. Blue Cross & P.S.I. employer shared. Transferrable accumulative sick leave & pension plans. Workmen's Compensation. Group ins. available. Transportation provided or allowance — 10¢ first 2,000 mi., 8¢ per mi. thereafter. 5-day wk. 1 mo. vacation with extra time at Christmas. Salary scale: \$3,000 for inexperienced nurses to start with annual increments of \$150. All starting salaries dependent on experience. For further information please write supplying details of training & experience to Medical Officer of Health, City Hall, Peterborough, Ont.

## DIRECTOR OF NURSING

for

VICTORIA HOSPITAL, RENFREW, ONTARIO

Approximately 100-beds

School of Nursing with 30-40 students.

**Qualifications desired:** Degree or postgraduate certification in nursing service and school of nursing administration and some experience.

**Prerequisites:** Private 3-room apartment in residence; full maintenance and laundry provided.

**Initial salary:** \$250-\$300 per month, depending on qualifications and experience.

Apply, with references to

CHAIRMAN, PERSONNEL COMMITTEE, VICTORIA HOSPITAL, RENFREW, ONTARIO

## **See Quebec With Employment Rather Than A Tourist Visit**

### **OPERATING ROOM SUPERVISOR GRADUATE NURSES FOR GENERAL DUTY**

**Where?** Jeffery Hale's Hospital

**Why Unique?** Only English speaking hospital & training school in Quebec City

*For information write:*

**DIRECTOR OF NURSES, JEFFERY HALE'S HOSPITAL, 1250 ST. FOY, QUEBEC, P.Q.**

**Public Health Nurses** for generalized program, bedside nursing included. Rural area. Blue Cross & group ins. available. Good transportation policy. 4-wk. vacation after 1 yr., statutory holidays. Apply Dr. J. I. Jeffs, Lennox & Addington County Health Unit, Napanee, Ont.

**Public Health Nurse (1) for generalized program** in rural & semi-urban area adjacent to metropolitan Toronto. Excellent working conditions including pension plan, group ins. & transportation arrangements. Apply Dr. R. M. King, York County Health Unit, Newmarket, Ont.

**Public Health Nurse (August 1 or September 1)** for Dept. of Health Staff. Must have P.H.N. Certificate. R.N.A.O. salary & hours. \$540 car allowance per yr. 1 mo. annual vacation. Sick time. Apply of Health, 100-8th St. E., Owen Sound, Ont.

**Public Health Nurses (qualified.)** Salary: \$3,100 depending on dist. served, less if in the Timmins area. Annual increment \$150 per annum for 4 yrs. Additional allowance for experience & if French-speaking. 5-day wk. 4-wk. vacation, 18 days sick leave annually (cumulative.) Car is provided. Half cost of uniform is allowed & half of Blue Cross. Workmen's Compensation. Good working conditions. Apply Sec.-Treas., Porcupine Health Unit, 164 Algonquin Blvd. E., Timmins, Ont.

**Supervisor (qualified.)** Good salary. Extra allowance for experience if French speaking. 5-day wk., 4-wk. vacation, 18 days sick leave cumulative annually. Car is provided. Half cost of uniform is allowed & half of Blue Cross. Workmen's Compensation. Good working conditions. Apply Sec.-Treas., Porcupine Health Unit, 164 Algonquin Blvd. E., Timmins, Ont.

**Public Health Nurse for an expanding program in a growing suburban municipality.** Minimum starting salary: \$3,200 with regular merit rating increases & car allowance. 20 days vacation after 1 yr. service. Address inquiries to the Personnel Director, Township of Etobicoke, 4941A Dundas St. W., Toronto 18, Ont.

**Registered General Duty Nurses (3) for 19-bed hospital** in oil town 95 mi. S.W. of Edmonton. Close to Sylvan & Gull Lakes. Daily bus service to Edmonton. Salary: \$200 per mo. plus maintenance & laundry. \$5.00 raise every 6 mo. for 2 yrs. 44-hr. wk. Apply giving full particulars to the Matron, Municipal Hospital, Rimbey, Alta.

**Nurse-Matron for reputable boy's school in Ontario.** Widow, 40-45 years old preferred. Boys 10-14 years old. Board & lodging supplied. Interview & references required. Apply Principal, The Junior School, Trinity College School, Port Hope, Ont.

## **GENERAL STAFF NURSES**

For 526-bed General Hospital with opportunity for advancement. Rotating or permanent day, evening & night assignments. 40-hr. wk. 6-hr. evening duty. Salary \$270 to \$310 with planned merit increases. Substantial evening & night bonus. Tuition assistance for university & college courses. On duty time may be arranged to accommodate college schedules. 2 wk. vacation after 1 yr. of service, 3-wk. after 2 yrs. 5-10 days paid sick leave. Uniforms laundered. Temporary housing available in the hospital residence at a nominal fee. Convenient public transportation.

*Apply:*

**DIRECTOR OF NURSING SERVICE, SAINT LUKE'S HOSPITAL, 11311 SHAKER BLVD.,  
CLEVELAND 4, OHIO**

## **PEDIATRIC INSTRUCTOR**

Responsible for classroom and clinical instruction in pediatric nursing & co-ordinating maternal & child care program in school where organizational set-up permits stressing of patient-centred care and student-centred learning activities.

*For further information apply:*

**DIRECTOR, SCHOOL OF NURSING, METROPOLITAN GENERAL HOSPITAL, WINDSOR, ONTARIO.**

## **GENERAL STAFF and PSYCHIATRIC NURSES**

*Required to staff*

New wing of 350-bed General Hospital.

Basic salary: \$250 per mo. with yearly increments of \$120 for 3 years.

Differential for evening & night duty.

*For further information apply to:*

**DIRECTOR OF NURSING SERVICES, METROPOLITAN GENERAL HOSPITAL  
1995 LENS AVENUE, WINDSOR, ONTARIO**

## **REGISTERED NURSES**

Sequoia Hospital in Redwood City, California, has openings on its staff for registered Nurses. Sequoia is a 218-bed District Hospital which was built in 1950 & to which a new wing was added in 1954. Redwood City, with its population of 42,000 is located 25 miles south of San Francisco. Its slogan, "Climate Best by Government Test," is appropriate. This is a community of beautiful homes & gardens, fine schools & churches, & a hospital in which the residents take great pride.

Salary: To start — \$300 per mo. with \$7.50 increase every 6 mo. to a maximum of \$330.

**(\$10 SHIFT & DEPARTMENT DIFFERENTIALS.)**

**Vacations: After 1 year — 10 days (2 wks.)**

**After 2 years — 15 days (3 wks.)**

**After 3 years — 20 days (4 wks.)**

**Social Security — Group Insurances — Credit Union**

*For further information, write*

**PERSONNEL OFFICE**

**SEQUOIA HOSPITAL, REDWOOD CITY, CALIFORNIA**



## **REGISTERED NURSES**

**\$2,610-\$3,360**

## **CERTIFIED NURSING ASSISTANTS**

**\$2,040-\$2,220**

**SUNNYBROOK HOSPITAL  
TORONTO**

**WESTMINSTER HOSPITAL  
LONDON**

Application forms, available at your nearest Civil Service Commission Office, National Employment Service & Post Offices, should be forwarded to the

**CIVIL SERVICE COMMISSION,  
25 ST. CLAIR AVE. E., TORONTO 7, ONTARIO**

## **GENERAL STAFF NURSES**

*for*

*200-bed hospital*

**Pleasant city of 38,000. Three colleges.**

**Good salary and personnel policy.**

*For further information apply to:*

**DIRECTOR OF NURSES, GENERAL HOSPITAL, GUELPH, ONTARIO**

### **REGISTERED NURSES NURSING ASSISTANTS ORDERLIES**

Required for all Departments in  
New 150-bed General Hospital

Excellent Salary & Personnel  
Policies

Hospital scheduled to open  
August 1st, 1956

*Apply*

**DIRECTOR OF NURSING,  
QUEENSWAY  
GENERAL HOSPITAL  
TORONTO 14, ONTARIO**

### **EDUCATIONAL DIRECTOR**

*for*

**SCHOOL OF NURSING**

**Saint John General Hospital**

**DUTIES TO COMMENCE JULY 1, 1956.**

Degree in nursing education with  
experience required.

New Educational Department  
opening in March, 1956.

Expected registration 200 students.

**APPLY: DIRECTOR OF NURSING,  
SAINT JOHN GENERAL HOSPITAL,  
SAINT JOHN, N.B.**

## **GRENFELL LABRADOR MEDICAL MISSION**

The Grenfell Mission requires a Laboratory Technician, Occupational Therapist and Nurses for their headquarters at St. Anthony, Newfoundland. These are positions which combine work in a modern hospital with the opportunity for service to the people of the Canadian Northland.

For full information please write:

**MISS DOROTHY A. PLANT, SECRETARY**

**GRENFELL LABRADOR MEDICAL MISSION, 48 SPARKS ST, OTTAWA 4, ONTARIO**

### **REQUIRED IMMEDIATELY**

**Obstetrical Supervisor (Qualified)**

**Head Nurse, Nursery**

**(Postgraduate experience preferred)**

**General Staff Nurses, All departments**

**(\$225 per mo. plus laundry)**

New 300-bed General Hospital. Excellent Personnel Policies.

*For further information apply:*

**Director of Nursing, Memorial Hospital, Regent St. S., Sudbury, Ontario.**

## **NURSING INSTRUCTRESS**

**(Immediately)**

Registered Nurse with experience & preferably postgraduate training in Psychiatric Nursing & Nursing Instruction to teach affiliate student nurses rotating through new 25-bed psychiatric ward in the Union Hospital, Moose Jaw.

**Salary range:**

**\$288-\$350 per month.**

Application forms are available from the

**PUBLIC SERVICE COMMISSION,**

**LEGISLATIVE BUILDING,**

**REGINA, SASKATCHEWAN**

## **MOOSE JAW UNION HOSPITAL**

### **PSYCHIATRIC WARD**

*requires immediately*

**REGISTERED NURSES \$232-\$288**

This new 25-bed institution is being opened by the Saskatchewan Dept. of Public Health. Applicants should be registered with their professional assoc. & have some successful nursing experience.

Application forms are available from the

**PUBLIC SERVICE COMMISSION,**

**LEGISLATIVE BLDG., REGINA, SASK.**

**& should be filed immediately.**

## **VICTORIAN ORDER OF NURSES FOR CANADA**

*has Staff and Supervisory positions in various parts of Canada.*

### ***Personnel Practices Provide:***

- Opportunity for promotion.
  - Transportation while on duty.
  - Vacation with pay.
  - Retirement annuity benefits.

*For further information write to:*

**Director in Chief,**  
Victorian Order of Nurses for Canada,  
193 Sparks Street, Ottawa 4, Ont.

## **UNIVERSITY HOSPITAL**

**SASKATOON, SASKATCHEWAN**

### ***Requires***

General Staff Nurses for Medical, Surgical, Obstetrical and Pediatric Services. Forty-four hour week. Salary \$220 to \$260 gross per month. Differential for evening and night duty, Residence Accommodation if desired.

*Apply to:*

**DIRECTOR OF NURSING, UNIVERSITY HOSPITAL,  
SASKATOON, SASKATCHEWAN**

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Duties include nursing services for employees, their families & the community, acting as intermediary between patients & non-resident doctors. Home visits to sick or injured. Arranging for & assisting doctor in weekly clinics. Cooperate with First Aid Group, providing nursing service to accident cases on property. Other related duties. Emergency hospital at property.

Accommodation available with modern conveniences.

**Starting salary: \$325 per month.**

**Application should be made in writing to:  
MANAGER, PERSONNEL DIVISION,  
THE CONSOLIDATED MINING & SMELTING  
CO. OF CANADA LTD., TRAIL, B.C.**

## **SCIENCE INSTRUCTOR**

**and**

## **NURSING ARTS INSTRUCTOR**

**for**

## **SCHOOL OF NURSING**

(In operation since 1908)

**Registration: 100 students**

**New Rochelle Hospital  
Degree in nursing education with  
experience required.**

**Salary open**

**APPLY: ALEX E. NORTON, Superintendent  
NEW ROCHELLE HOSPITAL  
NEW ROCHELLE, NEW YORK**



# Official Directory

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# BABY'S OWN SOAP

*a favorite for over eighty years!*



Baby's Own Soap is a pure soap, super fatted with a special extract of lanolin, to make it mild and gentle for the tender skin of babies. It contains no free caustic soda, no coloring agents or fillers. Thorough tests show that components of the perfume which gives Baby's Own its fresh and delicate aroma are entirely free of elements which would affect the normal skin of babies. Its rich lather gets baby's skin thoroughly clean and clears tiny pores of impurities.

For over 80 years, Baby's Own Soap has been the favorite of Canadian mothers. It has won this long standing faith because it is a product of rigid laboratory control. Automatic processing and close inspection assure uniformity of its high standard of quality. Finally each cake of Baby's Own soap is individually wrapped and boxed to ensure protection of its purity right to the time of baby's bath.

## Baby's Own 3 step-care



# THE CANADIAN NURSE

## *L'Infirmière Canadienne*

VOLUME 52

NUMBER 9

SEPTEMBER 1956

- 678** NEW PRODUCTS
- 687** PRAIRIE CONVENTION
- 699** SASKATCHEWAN'S EXPANDING  
HEALTH SERVICES.....*T. J. Bentley*
- 703** AND THE WORLD TOO.....*Helen G. McArthur*
- 706** STUDENT DAY ACTIVITIES.....*Edythe Wildfang*
- 708** CHANGING ATTITUDES.....*Elisabeth C. Phillips*
- 712** GLOMERULONEPHRITIS.....*Sr. Mary Doris*
- 715** LIFE, PROFESSION AND SCHOOL.....*Sir Fred Clarke*
- 722** IN MEMORIAM
- 724** LEUKEMIA.....*W. Schweisheimer*
- 728** QUELQUES CONSIDÉRATIONS SUR L'ANÉMIE  
ET LES ETATS ANÉMIQUES.....*Eugénie Tessier*
- 734** NURSING ACROSS THE NATION
- 738** LE NURSING À TRAVERS LE PAYS
- 742** SÉLECTION
- 744** BOOK REVIEWS
- 752** NEWS NOTES
- 758** EMPLOYMENT OPPORTUNITIES

*Editor and Business Manager*  
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Single copies, 35 cents.

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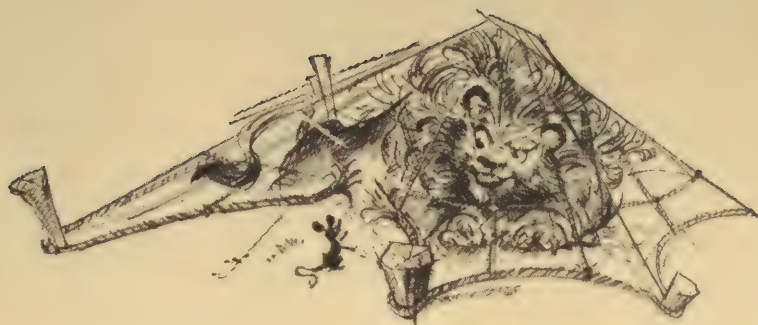
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Member of Canadian Circulations Audit Board.

**1522 Sherbrooke Street, West, Montreal 25, Quebec**





## A Lion and a Mouse

Upon the roaring of a Beast  
in the Wood, a Mouse ran  
presently out and saw a  
Lion Hamper'd in a Net.  
Upon a strict Enquiry, she  
found this to be the very

Lion that let her go when  
she had fall'n under his  
Paw. So she set herself to  
gnaw upon the Threds and  
deliver'd her Preserver.

**The Moral:** *"The Great and the Little have need of one another."*

Just so, even the smallest contribution to the care of our babies is important.

### Borden's Nutrilac

(partly skimmed Evaporated Milk) provides 2% fat diluted with equal parts of water, specially prepared for the Infant Feeding Formula which requires a lower fat content. Nutrilac has a high protein to fat ratio

- evaporated to double concentration
- homogenized for easy digestion
- sterilized in sealed containers
- simplifies formula preparation

COMPOSITION			
Butterfat	4.0%	Minerals	1.5%
Protein	6.9%	Total Milk Solids	22.0%
Lactose	9.6%	Calories per ounce	32
800 I.U. Vitamin D per reconstituted quart.			

### Other Borden Formula Foods

Dryco, Starlac, Multi-Soy, Lactic Acid Milk Powder (C.M.P. Brand), Protein Milk Powder (C.M.P. Brand), Evaporated Milk

For detailed information on Borden Formula Foods, write

**THE BORDEN COMPANY, LIMITED**

Formula Foods Dep't., Spadina Crescent, Toronto, Ontario.

# Between Ourselves

ANYONE WHO HAS EVER been associated with the planning for and subsequent follow-up of a convention will know how busy our National Office secretaries have been and are. We at the Journal office do not have the preliminary responsibilities — ours begin after the convention is over. Then we begin to sort out the impressions, the reports and the addresses so that they may be shared completely and quickly with you.

In previous years the timing of the convention has permitted us to write the day-by-day story of happenings and have it ready for the August issue. This year, our plans were being made to send wire releases to our office to beat the deadline when Gladys J. Sharpe graciously consented to have her presidential address appear as the lead article for August. The detailed story of the convention is therefore included in this issue.

As is noted in that story, the individual reports of committee chairmen, the general secretary-treasurer and the editor will not be published in *The Canadian Nurse*. Instead, the highlights of the reports have been incorporated into "Prairie Convention."

Folios of the reports, in both English and French, were at hand for the convention registrants. A small supply of them is still available for distribution at National Office. Since it will be a case of first come, first served, if you wish a copy for your own reading, write without delay to the CNA, 270 Laurier Ave., W., Ottawa.

When are the various addresses to be published? The following schedule has been worked out and, unless something very unexpected happens, they will appear as follows:

- September* Keynote Address — Hon. T. Bentley.  
Closing Address — Helen G. McArthur.
- October* Mary Agnes Snively Lecture — Byrne Hope Sanders.  
Signpost at Geneva — Dorothy M. Percy.
- November* Nursing Education — Margaret Arnstein.  
Nursing Service — Mildred Schwier.  
Address by Adelaide Sinclair.

\* \* \*

Everyone likes to receive letters. This

generalization fits your editor as closely as it does all of the readers of the Journal. There is a sense of anticipation every time the mailman arrives. What will there be this time?

As may well be imagined, a very considerable portion of the mail each day at the *Journal* office consists of changes of address. We are so glad to have these promptly so that we may guard against any interruption in the delivery of your copies to you. However, there are a few ways in which you can assist us to make the change of address business even faster. Since the subscriptions for nearly 29,000 of our subscribers are sent to us by the provincial nurses' associations, an index card system has now been set up on a provincial basis. When Mary Jones, let us say, writes us saying only, "Please change my address to thus-and-so," we are stuck! Which Mary Jones is she? Where did she live previously? There is nothing to do but write her and ask. So, please —

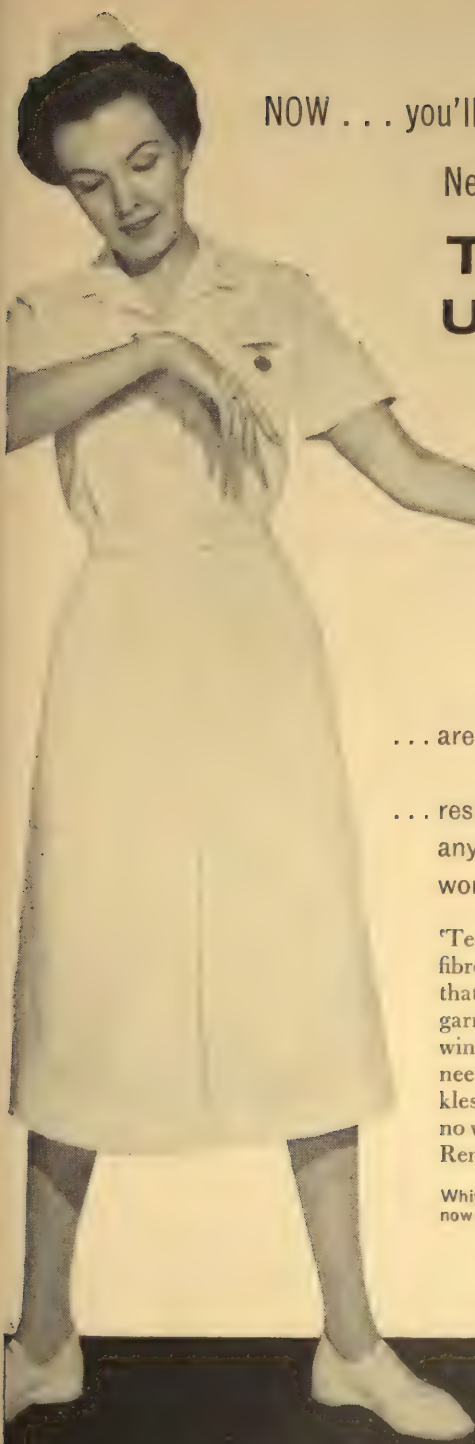
**Give your name, province, registration number, old address, new address. If you have been married, tell us your maiden name, too.**

The above procedure would be greatly simplified if you would simply clip your name and address from the envelope in which your copy reaches you. Pin it, stick it on with Scotch tape or the nurse's old reliable, adhesive. Write your new address and change of name, if any, below. Simple, isn't it?

Remember, neither your provincial association nor the post office assumes the responsibility for keeping us posted regarding your changes of address. Nor do we accept any obligation for replacing issues that are lost or undelivered because they went to the wrong address. Help us to serve you!

\* \* \*

Another kind of letter that comes often is the one that seeks information on any one of a thousand topics. Sometimes the letters are referred immediately to one or another of the secretaries at National Office. Inquiries relating to nursing education, to postgraduate courses, to a possible listing of the hospitals in Yukon or the West Indies rightly should go to the people who have this information readily available. If you have forgotten which secretary does what, refer to the last section of the CNA Official Directory.



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. . . are not yellowed  
by detergents  
. . . resist wrinkles better than  
anything you've ever  
worn before

'Terylene', the talented new textile fibre brings you smart, new uniforms that are about as "work-free" as any garments could be. They wash in a wink, drip-dry in a couple of hours and need practically no ironing. No wrinkles while you wear 'Terylene', and no wrinkles after washing 'Terylene'. Remember, it *stays white*, too!

White Sister Uniforms of 100% 'Terylene' are now available in stores across the country.

*keep your eye on*



\*Registered trade-mark polyester fibre



# New Products

Edited by DEAN F. N. HUGHES

PUBLISHED THROUGH COURTESY OF *Canadian Pharmaceutical Journal*

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## NEO-BARB DURES TABLETS

**Manufacturer**—Neo Drug Company, Montreal.

**Description**—Each tablet contains 45 mg. ( $\frac{3}{4}$  gr.) butabarbital in a special formulation for slow release over 10 to 12 hours.

**Indications**—For simple insomnia, nervousness.

---

## PACATAL

**Manufacturer**—Warner-Chilcott Laboratories Co. Ltd., Toronto.

**Description**—N-methyl-piperidyl-(3)-methyl phenothiazine, in 25 mg. and 50 mg. tablets and in 2 cc. ampoules (1 cc. = 25 mg.).

**Indications**—Used for the treatment of mental disturbances characterized by anxiety, restlessness, excitement and abnormal behavior ranging from lesser emotional disorders to severe mental illness. Used to potentiate analgesics and opiates in intractable pain including cancer. In minor surgery with local anesthesia quiets patient and reduces apprehension.

**Administration**—Severe mental cases 50-100 mg. orally t.i.d. Mild mental cases 25 mg. orally t.i.d.

Peanesthetic medication 50-100 mg. orally at bedtime the night before the operation, followed by 150-250 mg. orally or intramuscularly 1 or 2 hours preoperatively or intravenously 15 minutes before general anesthesia.

---

## PARASAL-S.A. e INH

**Manufacturer**—Panray Corporation, N.Y. **Can. Dist.**: Winley-Morris Co., Montreal.

**Description**—Contains 0.5 gm. of P.A.S. (para aminosalicic acid); 20 mgm. of isoniazid in the centre of tablet, coated for delayed action; 0.5 gm. of P.A.S. buffered with dihydroxy aluminum aminoacetate and calcium carbonate; 20 mgm. of isoniazid in the outside coating for immediate absorption.

**Indications**—In the treatment of tuberculosis.

**Administration**—8 to 12 tablets per day in divided doses as directed by the physician.

---

## PERSISTIN

**Manufacturer**—Sherman Laboratories, Detroit 11, Mich., and Windsor, Ont.

**Description**—Each light yellow, scored tablet contains: Acetylsalicic acid  $2\frac{1}{2}$  gr. and salicylsalicic acid  $7\frac{1}{2}$  gr.

**Indications**—Relief of pain and distress during hours of sleep; arthritic and rheumatic involvements, bursitis, myalgias, neuralgias, and other types of pain relieved by salicylates; fever and distress of upper respiratory tract and other infections. Analgesic levels of salicylate persist in the blood for 5 to 8 hours following a single dose.

**Administration**—Adults, 3 tablets before retiring. Children, age 2 to 4,  $\frac{1}{2}$  tablet; age 5 to 9, 1 tablet; age 10 to 12,  $1\frac{1}{2}$  tablets; age 13 and over, 2 tablets.

---

## SERTENS

**Manufacturer**—Ingram & Bell Limited, Toronto.

**Description**—Reserpine crystalline, scored tablets of 0.1 mg. (white) and 0.25 mg. (yellow).

**Indications**—For control of essential hypertension in mild to moderate cases. Also as a tranquilizing agent in various anxiety states.

**Administration**—In hypertension and anxiety states the average daily dose is 1.0 mg. This dosage should be varied according to the patient's response.

---

## SPARINE

**Manufacturer**—John Wyeth & Brother (Canada) Ltd., Walkerville, Ont.

**Description**—Promazine 10-(gamma-dimethylamine-n-propyl-phenothiazine) HCl.

**Indications**—Treatment of the acutely agitated patient, such as the acute alcoholic, the acute psychotic and the drug addict.

**Administration**—Dosage and route of administration governed by the degree of excitation and the response.

**Acutely agitated patients**—50-150 mg. intravenously; if desired calming effect not apparent in 5 to 10 minutes, additional doses up to a total of 300 mg. may be given. Once the desired effect is obtained 25 to 200 mg. may be given intramuscularly or orally at 4 to 6 hour intervals.

**Acutely inebriated patients**—Initially, no more than 50 mg. Once the desired effect is obtained, administer in doses of 25 to 200 mg. every 4 to 6 hours.

**Contraindicated** in comatose states due to central depressants. Use with caution in cerebral arteriosclerosis, coronary disease or other conditions where a drop in blood pressure may be undesirable.

---

*The Journal presents pharmaceuticals for information. Nurses understand that only a physician may prescribe.*

# Answers to your questions about

## PRENATAL CAPSULES LEDERLE and CYESICAPS\*

Prenatal Vitamins-Minerals Lederle



PRENATAL CAPSULES LEDERLE and CYESICAPS are special vitamin-mineral capsules for use throughout pregnancy and lactation.

Both formulas provide the extra nutrients usually indicated during this period to help assure better health for mother and child.

CYESICAPS differ in that they provide calcium as calcium lactate—an easily assimilated form of calcium which is better tolerated by many women.

BOTH products are free of any unpleasant aftertaste because they are offered in dry-filled, sealed capsules (a Lederle exclusive).

*If you should like more information about this or any other Lederle product, speak to the Lederle representative.*



LEDERLE LABORATORIES DIVISION  
NORTH AMERICAN Cyanamid LIMITED  
MONTREAL, QUEBEC

### ANATENSIN FORTE

**Manufacturer**—British Drug Houses (Canada) Ltd., Toronto.

**Description**—Each capsule contains: Myanasin (mephenesin) 250 mg., acetylcarbromal 250 mg., reserpine 0.2 mg.

**Indications**—Anxiety neuroses, post-alcoholic tension states, neuromuscular hypertension, menopausal hypertension, anxiety with angina pectoris, neurogenic dermatitis, stress of psychogenic origin.

**Administration**—Suggested initial dosage: 1 or 2 capsules 2 to 4 times a day for 3 to 5 days; reduce gradually until minimum daily maintenance dose has been established.

---

### AZO-GANTRISIN

**Manufacturer**—Hoffmann-La Roche Limited, Montreal.

**Description**—Combines in a single tablet 500 mg. gantrisin, the broad-spectrum highly soluble sulfonamide for antibacterial action, and 50 mg. phenylazodiaminopyridine HCl for local analgesic action.

**Indications**—Urinary tract infections, when associated with pain and discomfort; particularly useful in cystitis, prostatitis and urethritis when due to susceptible organisms. Valuable following urologic surgery and diagnostic instrumentation.

**Dosage**—Two tablets, 4 times daily, or as directed by the physician.

---

### BONAMINE TABLETS

**Manufacturer**—Pfizer Canada, Montreal.

**Description**—Candy-coated chewing tablets containing 25 mg. of bonamine (meclizine hydrochloride) in a mint-flavoured base.

**Indications**—For the prevention of motion sickness in adults and children.

**Administration**—Chew one tablet one hour before commencing travel.

---

### CONSTIBAN

**Manufacturer**—E. B. Shuttleworth, Limited, Toronto.

**Description**—Contains: Dioctyl sodium sulfo succinate, an unusually active wetting agent. Exerts no pharmacologic effect. By its physical wetting effect alone, penetrates and softens the bowel content with water.

**Indication**—Chronic constipation.

**Administration**—Tablets: 1 or 2 tablets daily. May be increased to 3 or 4 if necessary, then gradually decreased as function returns toward normal. Cathartic addicts should be "weaned" while taking a constant dose of constiban.

Liquid has a bitter taste. This is not noticeable when the recommended dose is mixed with the formula of  $\frac{1}{2}$  glass of milk or fruit juice.

---

### (PR) CORSALENT

**Manufacturer**—Canada Pharmacal Co. Ltd., London, Ont.

**Description**—Red sugar-coated tablet contains: Salicylamide  $4\frac{1}{2}$  grs., sodium para-amino benzoate  $3\frac{1}{2}$  grs. and hydrocortisone 1.0 mgm.

**Indications**—For the symptomatic relief of pain in arthritis and rheumatism.

**Administration**—Initially 3 tablets 3 or 4 times a day. Gradually reduce to minimum sustaining regimen until final discontinuance.

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### DEXAVITE

**Manufacturer**—Elliott-Marion Company Ltd., Montreal.

**Description**—Each "Extensule" (timed disintegrating capsules) contains: D-amphetamine sulphate 10.0 mg., vitamin A (synthetic) 6600 I.U., vitamin D (synthetic) 400 I.U., thiamine 1.6 mg., riboflavin 2.5 mg., niacinamide 15.5 mg., ascorbic acid 30.0 mg., ferrous gluconate 50.0 mg.

**Indications**—As a dietary adjunct in obesity; for the emotionally depressed patient, the convalescent or the aged. Contraindicated in presence of hyperexcitability and whenever vasoconstrictors should not be used.

**Administration**—Suggested dosage: 1 capsule daily, taken at 10 or 11 a.m.

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**Manufacturer**—Schering Corporation Limited, Montreal.

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**Administration**—Apply a small quantity on the affected areas 3 or 4 times daily.

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Only when we look back at the long course of our life and its general results can we see the why and wherefore of it all. A

thousand things become clear which were formerly obscure, and we gain a satisfying feeling of difficulties overcome. — *Health*



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SANATORIUM, KENTVILLE, N.S.**

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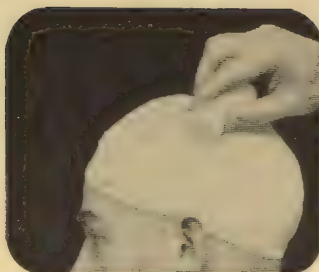
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Drawer 350  
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ROLLS

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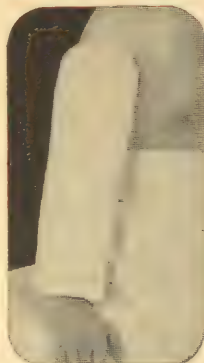
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THE NATIONAL HOSPITAL

# PSYCHIATRIC

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or Miss Kathleen Marshall, Supervisor of  
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2. Able to understand, read, write and speak English.
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4. Recommended by your school of nursing and by a recent employer.

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Interested applicants should write, providing a transcript of nursing school records, letters of reference as indicated and a report of a recent physical examination, to

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*For information write to:*

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The Johns Hopkins Hospital  
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Operating Room Training is scheduled  
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# THE CANADIAN NURSE

## *L'Infirmière Canadienne*

A MONTHLY JOURNAL FOR THE NURSES OF CANADA  
PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION

VOLUME 52

NUMBER 9

**MONTREAL, SEPTEMBER, 1956**

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## Prairie Convention

### PRELIMINARIES

WHEN, ON JUNE 25, 1956, the Honorable D. L. Campbell, premier of Manitoba, declared the 28th biennial convention of the Canadian Nurses' Association officially opened the united efforts of dozens upon dozens of nurses were brought into focus to produce one of the finest and most stimulating conventions on record. As with any good thing, months of planning, hundreds of hours of attention to myriads of details, thousands of letters between individuals, between committees to and from National Office, had been necessary to furnish the preliminary ingredients for success. How would the finished product "take"?

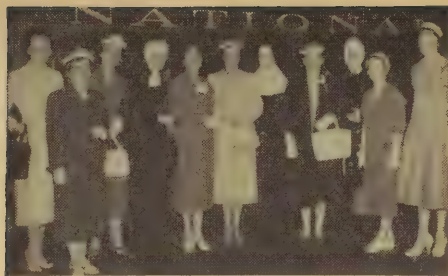
The first hurdle that had to be overcome was the fact that two provincial nurses' associations, not just one as for all the preceding 27 conventions, were serving as joint hostesses. What could be used as the motif that would be distinctively characteristic of both Manitoba and Saskatchewan? Both were prairie provinces. Both had been opened up initially by fur traders. Both had seen hundreds of settlers arrive to lay claim to vast acreages as home-

steads. What could be more typical of each than the old covered wagons that once had jogged across the plains? Hundreds of women in sunbonnets and full skirts had accompanied their menfolk on this trek to distant parts of both provinces. So "Covered Wagons" and "Sunbonnet Sues" were chosen.

With the advice of Professor J. A. Russell of the Department of Architecture of the University of Manitoba and the active assistance of Mr. Grant Marshall from the Department of Interior Design, the main entrance to the convention hall was adorned with replicas of covered wagons. There, in gaily colored sunbonnets that had been provided by the nurses of Saskatchewan, were installed the "know-the-answer" girls, with INFORMATION spelled out in twigs.

### THE TRAVELLERS

By train, by plane, by bus, by car, nurses poured into Winnipeg over the weekend. As in 1954 the railways had provided special nurses' trains from eastern Canada. Once again, a program of fun and games and a steady flow of gifts made the time go even



*All aboard!*

faster than the train. After captains were appointed for each coach, programs were distributed, each with a bottle of perfume attached to a straw hat. A fresh yellow or red rose was given to each passenger at breakfast. During the day there was a drawing for special prizes that had been



*Fun en route*

donated. A sherry party before dinner and a sing-song afterwards made it a happy day. The student nurses who were allowed to borrow the saris from the Indian nurses attending McGill



*In borrowed finery*

will not soon forget the pleasure of beautiful garments.

The Sunbonnet Sues met each train and plane — even in the wee small hours of the morning. Soon the dormitories at the University, the major hotels and most of the motels along Pembina Highway were thronging with nurses from every part of Can-



*At the station*

ada. The record for distance travelled, expressly to reach the convention, surely goes to Miss Marion West, deputy editor of *Nursing Times*, and editor of the *Journal for Industrial Nurses* who flew over from London, England.

## SUNDAY

While Executive Committee members attended to business at the pre-convention board meeting, glimpses of the city and surrounding area were provided for the visitors. Dozens of cars were driven by alumnae members, their husbands or brothers, who took advantage of the beautiful day to give more than 150 nurses privately conducted sightseeing tours. Some of the groups were later entertained to supper parties at the homes of their hosts.

## CHURCH SERVICES

Special church services were arranged, the Protestants going to Westminster United Church, the Roman Catholics to St. Mary's Cathedral. Those attending the latter service were guests at a reception given by the Sisters at Misericordia Hospital later that evening.



## SIMULTANEOUS TRANSLATION

To ensure complete understanding of every part of the program, 50 pairs of earphones were available to any who wished to listen to the simultaneous translation into French. Perhaps it is an indication of an unsuspected degree of bilinguality that seldom were more than half of the earphones in use. Still, they were used by a few at every session which certainly justified the expense incurred.

Starring in the role of translators were quick-thinking and nimble-tongued Andrée Francoeur and Blake T. Hanna of Montreal. Graduates of the Institute of Translation, University of Montreal, the pair, who spelled each other off at half-hour intervals, were able to keep only four or five words behind the speakers. The bewilderment on the listeners' faces when the translators turned remarks that were made in French back into English was amusing.

## OPENING CEREMONIES

The fact that 13 persons were in the procession that went to the platform for the opening ceremonies did not cause a tremor in even the most superstitious. Perhaps it was a lucky number after all for this proved a most auspicious opening to a highly successful convention.

Hon. D. L. Campbell, in welcoming the Canadian Nurses' Association to Manitoba, commented that the vast, sparsely settled areas of our country demand a healthy, virile people capable of undertaking the gigantic tasks that confront them. The provision of adequate nursing services is basic to the maintenance of healthy citizens in rural as well as urban areas.

The president of the University of Manitoba, Dr. H. H. Sanderson, in pronouncing the invocation used a most appropriate prayer of the late Dr. Peter Marshall that we "might be part of the answer and not part of the problem" in the coming sessions.

Mary MacKenzie, president of the Saskatchewan Registered Nurses' Association noted that the convention program had been designed to "feed the minds of the members. Your hos-



*Buses brought nurses from town*

esses will do everything else!" Marie LaCroix, newly elected president of the Manitoba Association, gave an equally warm welcome to all of the visitors.

The keynote address, delivered by the Honorable T. J. Bentley, Minister of Public Health for Saskatchewan, appears elsewhere in this issue. President Gladys Sharpe's opening address was published last month. Emphasizing the convention theme, Miss Sharpe said "If tomorrow's pattern is to reflect our theme — Nursing Serves the Nation — nursing progress demands constant challenge, bold thinking, critical study, pointed discussion and trial in the practice of new ideas."

## REPORTS

A mimeographed folio of the reports of association and committee activity was provided for each registrant. These reports will not be printed but any nurses desirous of receiving the folio should send their request immediately to the National Office of the CNA, 270 Laurier Avenue West, Ottawa. In this story, the highlights from each of these reports will be included so that every nurse in Canada may have an opportunity to know the gist of the material presented.

## PUBLIC RELATIONS

Evelyn Pepper, chairman, noted that the committee had assumed, as its major responsibility, the production of a public relations guide. Published in both English and French, this at-



tractive, illustrated 49-page booklet, "represents the clearest interpretation of the need for, and the principles involved in, the establishment of a distinctive public relations program for nursing, as well as the techniques through which such a program can be accomplished." Copies are available at \$1.00 each from the CNA office.

In an endeavor to promote an increased public awareness of the multiple aspects of nursing service, a recommendation was approved that the Postmaster General be approached, through a brief, with the request that a special stamp be printed in 1958, its issuance to coincide with the 50th anniversary of the formation of the Canadian Nurses' Association.

An interesting symposium discussion of the many methods nurses should use to "Inform the Nation" revealed that public relations start at the patient's bedside. Prof. Stuart Tweedie, director of adult education at the University of Manitoba, stated that it is not enough to be aware of the traditions and reputation of our profession — positive steps must be taken by every nurse to safeguard them. Since we enjoy the respect of the public to such a considerable degree we must be ready to take the lead in fighting for the improvement of conditions that affect the health and well-being of people. At the same time we must never lose sight of our primary goals — kindness, charity and human understanding. "Don't let efficiency become officiousness," he said.

Mr. R. S. Malone, vice-president of the *Winnipeg Free Press*, advised us to ask ourselves two questions when working out any new plans in nursing education or nursing service — what

will be the effect on our patients? What will the public's reaction be? He suggested that nurses should move quickly to produce the accurate facts whenever the profession suffers from gossip or misinformation. We should never try to hush up criticism but should show what is to be done to correct errors in understanding.

#### GENERAL SECRETARY'S REPORT

M. Pearl Stiver noted that the membership of the CNA, as at December 31, 1955, was 41,208, almost five times as large as it was in 1932 when membership in the CNA was narrowed from provincial alumnae and local associations to the present pattern of provincial association federation.

Last March a brief was submitted to the Royal Commission on the Economic Future of Canada that emphasized the demands of Canadians for "more complete nursing service." Coupled with population increase, this demand should be answered by doubling the current nurse complement by 1980, the brief stated. Wider demands on nurses engaged in occupational health programs were envisaged as the greater industrialization of our country progresses and as more attention is given to the worker's health problems.

#### THE CANADIAN NURSE JOURNAL

The editor lauded the nurses of the eight provinces who have added to their professional stature by the acceptance of their personal responsibility for their own journal by amending their provincial association membership fees to include the annual subscription to *The Canadian Nurse*. As of June, 1956 the circulation is over 34,000 — an imposing increase of some 600 per cent in 12 years. With this greatly increased, assured circulation, an upward revision has been made in advertising rates. Though the *Journal* will be maintained at its present number of pages for the immediate future, as finances permit a larger and ever more useful periodical is promised.

On behalf of the Editorial Board, Isobel MacLeod, chairman, urged the nurses of Canada to share with others their thinking on professional matters, their new adaptation of old patterns



*Attentive delegates*



MRS. TOOHEY at the booth

of service and the developments in nursing education. The *Journal* is the logical place for such information to be spread.

Mrs. MacLeod noted that official sanction had been given to the inclusion of the word "Journal" in the name in all respects excepting the title of our periodical.

#### BARBECUE SUPPER

With the Governments of Manitoba and Saskatchewan as the hosts, the 947 registrants and the numerous exhibitors were entertained at a most delicious meal in the Student Union Building. To those who stood near the end of the lengthy line, waiting to enter the assembly room, it seemed as if there would be an interminable delay. Yet, so efficient was the staff at the serving tables, that the commissioner on duty at the entrance reported later that everyone had been generously helped to barbecued beef, salad, strawberry shortcake and coffee in 30 minutes and 33 seconds!

A joyous program of music was provided by some of the Winnipeg ethnic groups following the dinner. Several CNA members added to the evening's enjoyment by the uniqueness of their attire!

#### TUESDAY

##### FINANCES

The first part of the morning's session was devoted to a consideration

of the value received from the \$2.00 per member affiliation fees received by the CNA. The income for the biennium was \$133,612. Trenna Hunter, Finance Committee chairman, used large graphs to demonstrate the apportionment of this sum to direct and indirect expense and compared those figures with the budget for the next biennium.

Miss Stiver, as treasurer of the CNA, noted that provision is made in the Association Bylaws for associate members. They may attend conventions but may not act as voting delegates from their provincial association.

#### LEGISLATION AND BYLAWS

The effectiveness of the sweeping changes made in the structure of the associations laws in 1954 was indicated by the very modest list of adjustments that Helen Carpenter had to present on behalf of her committee. Each item received unanimous approval. Included were: The deletion of "publicity" from the title of the Committee on Public Relations; full membership on the Executive Committee of the CNA for the chairman of the Editorial Board of *The Canadian Nurse*. The committee recommended that a study be made of the terms of reference of the Editorial Board since these have not been revised since they were set up in 1944.

Special consideration was given to nurses working in the Yukon territory. Since they, may or may not belong to one of the ten provincial associations, they present a special problem in so far as CNA membership is concerned. It is hoped that eventually their group will be large and interested enough to justify opening the Act of Incorporation to admit them to membership.

#### \$64,000 QUESTION

With Albert Wedgery, R.N., as capable master of ceremonies, a clever and amusing quiz program, a take-off on the television program, provided the members with a painless method of reviewing the set-up of the national association, its history, officers and constitution. Unhappily, the large number of student nurses, who know



all too little about association affairs, were missing from the audience. The quiz would be readily adaptable to a chapter or district meeting and it is to be hoped nurses in many areas will concoct their own questions.

#### STUDENT NURSES

Each student had been asked to bring her uniform for the special session arranged for students only. What a picture they made in their pink or blue or all white uniforms. The rapt attention given to the four student speakers on the panel, whose skill in answering questions was noteworthy, promises well for the future of our



*At the students' sessions*

profession. Buzz sessions viewed quite weighty questions in objective fashion. The excellent report, drawn up for presentation to the CNA on Friday afternoon, appears in this issue.

#### ON YOUR OWN

Tuesday afternoon was play time. Despite occasional showers it was a good day for fun. A large number went on the five-hour historical sites tour winding up for tea at Lower Fort Garry, the only one of the old landmarks that is still in its original state — dungeon and all.

A larger group went boating. Winnipeg is situated at the junction of the Red and Assiniboine Rivers. As such it is becoming quite boating conscious. The Manitoba Yacht Club is very proud of its new 440-foot dock and club house at Middlechurch. Mr. Gilbert Eaton, president of the club, generously arranged for a mammoth flotilla of little boats and big, white and brown. In these, 160 nurses, obe-

dient to the injunction "No high heels," enjoyed box lunches or hot dogs and soft drinks as they admired the beautiful green shores and raved over the long-lingering prairie sunset.

Many nurses went for their first airplane ride when, through courtesy



*Boarding the "Viscount"*

of T.C.A., half-hour flights over Winnipeg in the luxurious Viscounts were provided in the early evening.

A special dinner party at the home of Mrs. J. E. Wilson, chairman of the Arrangements Committee, away out on the shores of Lake Winnipeg, was thoroughly enjoyed by the members



*In a frivolous mood*

of the CNA Executive Committee as guests of the two hostess associations.

A feature of the evening was an entertaining variety show on Rainbow stage at Kildonan Park, arranged especially for the Canadian Nurses' Association. As well as presenting musical numbers, some members of the Royal Winnipeg Ballet danced.

#### WEDNESDAY

##### DRAMATIZATION

Emphasizing the over-all theme of





*A simulated staff conference*

the convention — Nursing Serves the Nation — the morning session consisted of a dramatic presentation "Toward Better Nursing." Lillian Campion, nursing service secretary of the CNA, had evolved an interesting script depicting a staff conference discussion of the Head Nurse Study. Emphasis was placed on the importance of the head nurse's role in improving the quality of patient care. Relieving the head nurse of non-nursing duties, better preparation for her administrative functions, orientation and in-service education programs and closer cooperation with community nursing services were suggested as essential steps toward reaching this goal of improved patient care.

The caste of Montreal nurses are to be congratulated on their realistic presentation. This dramatization would make a stimulating addition to a provincial annual meeting. Copies of the script may be secured by writing to Miss Campion at the CNA office in Ottawa.

#### NURSING SERVING COMMITTEE

Alice Girard, chairman of our national committee, reported that careful consideration had been given to the preparation of a Canadian Code of Ethics. With one relatively minor change, the Code that had been approved by the International Council of Nurses in 1953 was accepted as the Canadian Code. It was proposed that it should be printed on pocket-size cards for distribution to the membership.

An Orientation Manual has been printed in both English and French and is available from National Office at 25 cents a copy.



*Bringing in community workers*

A "Statement of Policies regarding Nursing Service" was presented for approval. It will shortly be available in printed form. The most urgent need, now, is for research into the development of some measuring stick for estimating nursing staff requirements. The ultimate aim of the research would be to provide all agencies employing nurses with a guide for estimating their staffing needs.

#### NURSING RESEARCH

Miss Margaret Arnstein, chief of the Division of Nursing Resources, U.S. Public Health Services, was guest speaker at the afternoon session. Her address will be printed in full in an



MARGARET G. ARNSTEIN

early issue of the *Journal*. Speaking on the topic of improving nursing service with or without studies, Miss Arnstein noted that many hospitals had found that the answer to the shortage of nurses was better utilization of available personnel. She discussed several studies that are currently being made in the United States. "Research is not new in nursing, Florence Nightingale made careful studies . . . a hundred years ago . . . May her research lamp, as well as her lamp of comfort, continue to inspire us in the years ahead."

#### THE BIFOCAL APPROACH

The executive assistant to the deputy minister for welfare in our national health set-up, Dr. Adelaide Sinclair, was the guest speaker on Wednesday evening. She compared our approach



(Bradford Brachrach, Ottawa)

#### DR. ADELAIDE SINCLAIR

to health problems with the ranges of vision of a person wearing bifocal glasses. Looking through the lower segment we are confronted with a mass of details that sometimes blinds us to the broad approach. We need to look through the upper part now and then to see the far horizons. "Our complex society has created problems of stress and strain. The public is asking more of nurses and other professional groups in meeting those problems." There are many encouraging features. Today

there is less apathy and resignation and more knowledge. Those who need help are more willing to receive it. Many new avenues of help are now available — family allowances, old age security, and so on.

#### THURSDAY

##### NURSING EDUCATION

In the absence of Evelyn Mallory, committee chairman, her report was read by Frances McQuarrie, CNA nursing education secretary. The work of the master committee was augmented during the biennium by several "task committees" who studied such assignments as: Nursing personnel for the care of the mentally ill; acceptable basic minimum requirements for registration; measures designed to improve the quality of nursing education, with special study of the development of a program for the evaluation and accreditation of schools of nursing.

##### PSYCHIATRIC NURSING

The question put to the special committee considering this topic was — how can nurses whose preparation has been confined to the care of psychiatric patients be helped to meet the broader "Registered Nurse" requirements. After much consideration the committee came to the conclusion that the best solution lies in the organization of a broad program — a combined course — that would fit the student for both psychiatric and general nursing. Though several different arrangements of time were plotted the consensus favored a four-year program. Since course content for schools of nursing is a provincial responsibility, details relating to curricula could not be specifically stated nationally. Though considerable effort has been put into the project, it is still in the exploratory stage.

##### REGISTERED NURSES

Though the committee was asked to propose acceptable basic minimum requirements relative to registration so that reciprocal registration between Canadian provinces might be facilitated little progress has been made to date.



Registration examinations utilizing the Test Pool Service of the (American) National League for Nursing have replaced locally prepared papers in five provinces — Alberta, British Columbia, Manitoba, Nova Scotia and Saskatchewan. Its use is currently being considered in some other provinces.

#### NURSING ASSISTANTS

Frequent adaptations and adjustments have become necessary in connection with the curriculum approved for this ancillary group in 1952. In order to have a clear picture of the needed revisions, a proposal was approved to make a study of the functions of nursing assistants. Following this study, it is planned "to review the curriculum for nursing assistants with a view to developing a program for this worker in conjunction with the curriculum for the basic nursing students." The latter study has been assigned to the respective provincial nursing education committees, paralleling their revisions of curricula for schools of nursing. It was pointed out that with nursing assistants becoming increasingly active as members of the nursing team, student nurses should be given a better understanding of their professional responsibility to and for the auxiliary group.

#### ACCREDITATION

This phase of planning received very careful consideration by the convention body. Following the presentation of the facts relating to evaluation and accreditation by to panel of experts, very ably chaired by Dr. Rae Chittick, thoughtful questions poured in. Interest was so keen that time had to be allocated for the experts to return to the platform later in the day to answer more questions. As will be noted in the record of approved resolution included near the end of this report, the voting delegates sanctioned a pilot study over the next two years and, when funds are available, evaluating schools in as many regions as possible, using the techniques and facilities of the National League for Nursing to develop our own procedures and criteria.

Sister Denise Lefebvre was recog-



MILDRED E. SCHWIER

nized as the best informed Canadian on every aspect of evaluation and accreditation.

#### CREATIVE NURSING

An active contributor in the panel discussion and guest speaker during the afternoon session was Miss Mildred Schwier, director of the Diploma and Associate Degree Programs for the National League for Nursing. Her paper, too, will be published in an early issue of the *Journal*. Miss Schwier questioned whether hospital boards, doctors, even nurses themselves are prepared to accept fundamental changes in nursing education. She pointed out that the quality of education given students today controls the kind of care patients will receive tomorrow. "Will future students be bored automations or creative nurses?" "How can the student nurse assigned six or seven patients to be washed, fed, dressed, medicated, ambulated and recreated find time to be a student?" she asked.

#### FASHION REVIEW

Thursday had been a "heavy" day as convention days go so the members turned with enthusiasm to the relaxation offered by the women of Dugald, Man. Organized originally to entertain visiting Women's Institutes, these ambitious ladies have assembled some 100 outfits of clothes and accessories. They depict fashions for women and children



from 1850 to fairly recent times. The star of the show was Mrs. F. Van Slyak. The running commentary was vastly amusing. Sorry you weren't there to see the show!

## FRIDAY

### WORLD HEALTH

Canadian nurses were justifiably proud of the fact that Dorothy M. Percy, chief nursing consultant, Department of National Health and Welfare, was a member of the Canadian delegation to the Technical Discussions on Nursing which took place at the Ninth General Assembly of the World Health Organization. Miss Percy's address entitled "Signpost at Geneva" will be published in full next month. She noted that "everyone present felt this to be an historic occasion, marking as it did the first time that nurses, doctors and health administrators, on a world scale, had sat down together to consider some facets of the complex problems of nursing."

### CIVIL DEFENCE

Following the intermission, the final panel group was assembled to point up some new approaches to civil defence. Chaired by Evelyn Pepper, three speakers gave a comprehensive if somewhat disturbing picture of the

problems differing ideologies have created in our world today. Dr. F. W. Kern, director of Religious Affairs in the American Civil Defence program stated that the church has more at stake, humanly speaking, in the conflict between communism and democracy than any other organization for its very life is in the balance. There is no free church in communist dominated countries. Without freedom, the church is hindered if not prevented from performing its mission of preaching salvation.

On the other hand, the church has the greatest possible contribution to make to the outcome. It has been said that spiritual conflict is the primary basis of the world-wide unrest. If this be so, then the church must be the source of our strength.

### CLOSING ADDRESS

Helen G. McArthur chose as the title of her inspiring address "And the World Too." During her period of service in Korea with the International Red Cross, Miss McArthur witnessed a practical demonstration of how the work of nurses transcends lines of race, color and creed. To the nurses from many lands who were assisting in the post-war efforts to build up the health of this sturdy people, Korean nurses demonstrated courage and fortitude in the face of overwhelming difficulties. They proved that good nursing does not depend upon "plumbing, electric lights, Gatch beds or complicated equipment."

"It seems to me the means whereby nursing serves the world is very much the same as the old-fashioned quilting bee. Individuals pool their time and materials, working together, each taking responsibility for the worth of their own section but recognizing the over-all pattern and the necessity of maintaining a standard of workmanship; frequently exchanging ideas and colors so that the finished product is beautiful to see and a comfort to the recipient. Then, too, there are so many side products of the quilting bee: friendship, understanding and true charity.

Miss McArthur's address is published in this issue. Several members expressed their regret that the actual



HELEN G. McARTHUR

speech had not been recorded so that the thousands of Canadian nurses who were unable to be present might have shared in the listening.

## ELECTIONS

Chairman of Scrutineers, Clara R. Aitkenhead announced the results of the voting. The following is the slate of officers for the 1956-58 biennium: President, Trena G. Hunter, Vancouver, B.C.; First Vice-President, Alice Girard, Montreal, Que.; Second Vice-President, Helen M. Carpenter, Toronto, Ont.; Third Vice-president, E. A. Electa MacLennan, Halifax, N.S. Nursing Sisterhoods: Maritimes, Sister Helen Marie, Saint John, N.B.; Quebec, Sister Mary Felicitas, Montreal; Ontario, Sister Mary Frances de Sales, Toronto; Western Canada, Sister Mary Laurentia, Moose Jaw, Sask. This widely dispersed group is truly representative of Canadian nursing leadership.



*The three tenses*

## RESOLUTIONS

Frequently the duties of a Resolutions Committee are more or less perfunctory. This convention was an exception. In addition to the courtesy resolution that expressed appreciation to an impressive list, the following resolutions were adopted:

*Resolved*, That the Executive Committee of the Canadian Nurses' Association

be asked to give consideration to the publication of an annual brochure which would contain current factual information about the profession of nursing in Canada.

\* \* \*

WHEREAS, There is no pledge officially accepted by the Canadian Nurses' Association for new practitioners, upon their acceptance into the profession of nursing, therefore be it

*Resolved*, That the Executive Committee of the Canadian Nurses' Association be asked to give consideration to the wording of such a pledge which could be taken by nurses upon graduation.

\* \* \*

WHEREAS, The Canadian Nurses' Association is a bilingual organization and

WHEREAS, The Executive Committee has unanimously agreed that the name on the crest be in both the French and English languages, therefore be it

*Resolved*, That the name of the Canadian Nurses' Association should appear in both languages on whichever one of the five models is chosen.

\* \* \*

WHEREAS, It is the responsibility of any profession to evaluate its own program of education, and

WHEREAS, A program of accreditation will benefit the health and welfare of the people of Canada by providing more effective nursing service through improving preparation for that service, and

WHEREAS, The principle of accreditation has been approved by the Canadian Nurses' Association, therefore be it

*Resolved*, That the Canadian Nurses' Association undertake without delay steps leading toward a program for the accreditation of schools of nursing, and

That the first step be, when funds are available, to conduct a pilot study involving schools in as many regions as possible.

\* \* \*

WHEREAS, Over a period of twenty years the National League for Nursing has developed techniques and facilities for accrediting schools of nursing in the United States, therefore be it

*Resolved*, That, in order to develop procedures and criteria for accreditation, the Canadian Nurses' Association request the assistance of the National





*At the reception*

League for Nursing in conducting the pilot study.

\* \* \*

WHEREAS, It is apparent that financial support for a pilot project of accreditation must be secured from various sources, therefore be it

*Resolved*, That the Executive Committee be instructed to explore all avenues of possible support, including that which may be secured through Foundations.

#### SNIVELY MEMORIAL LECTURE

Her delightful sense of humor, her keen appreciation of public affairs and her tremendous interest in people, including nurses, made Byrne Hope Sanders a splendid choice to deliver the Mary Agnes Snively Memorial Address. Its early publication is anticipated with great pleasure.

#### CLOSING

Gladys Sharpe, retiring president of the CNA, conducted the simple yet impressive installation ceremonies, welcoming first the vice-presidents then the new president to their respective office. As she received the gavel, symbolic of the presidency of our association, Trenna Hunter pledged her best efforts to uphold the traditions of the association and to give unstintingly of her time and energy in promoting the welfare of the nurses of Canada. Her theme

for the biennium was cast in the following words: "Into The Future, Open a Better Way."

It took over an hour and a half for the large assembly to pass along the receiving line at the reception sponsored by the six alumnae associations of the Winnipeg area.

#### AU REVOIR

There was a note of sadness in the farewells that were heard on every side. For a week nearly 1400 nurses had roamed the corridors of the University of Manitoba buildings. The weather had been cool enough to keep the auditorium comfortable.

Now the convention was over. It had been a good one, with interest high throughout. The program had been attuned to the needs and interests of the average nurse with sufficiently varied topics to meet the demands of the most querulous. In fact, the only serious criticism heard throughout was that the variety was too great to permit full absorption of even a single aspect. Perhaps more time for greater audience participation can be a goal for the next convention. Actually, it is a very healthy sign of professional maturity that so many wished that they had had more time to digest all of the information they had received before the program shifted to another topic.

The crowds that had thronged the exhibitors' hall found it quite a problem to stow away all of the samples they had obtained as they began to pack for the homeward trip. Some were already deep in plans for the trip to Rome in 1957 to attend the Congress of the International Council of Nurses. Most were ready to begin saving again so that they might be able to attend the next biennial meeting in Ottawa in 1958. There was a realization that that will be a very special occasion as the 50th anniversary of the founding of the Canadian Nurses' Association is celebrated.

The first nursing act in Canada was assented to in Nova Scotia on April 22, 1910. Manitoba's was passed on February 15, 1913, Alberta's on April

19, 1916 and New Brunswick's on April 29, 1916. The most recent, Newfoundland's, was passed on May 20, 1953.



# Saskatchewan's Expanding Health Services

HON. T. J. BENTLEY

## INTRODUCTION

ALL THROUGH CANADA, there has been a tremendous expansion of *organized* health services in the post-war decade. Partly this has come about because the war shocked us into a realization that we Canadians, living in one of the wealthier countries of the world, were not nearly as healthy as we should be. Partly, too, public opinion has demanded higher expenditures on health services because our collective conscience is more sensitive — we are no longer complacent over poverty, ill-health, and inequality of opportunity around us.

We have come so far and so fast in the last 10 years that it becomes most necessary for us to look back and see what has been accomplished. In this way, we obtain a clearer idea of our goals for the future, and how we should go about achieving these goals.

Nurses are involved in every aspect of health services. I propose, then, to touch on health service highlights which may be broadly defined in four categories: community preventive services, mental health services, medical care and hospital services, and what we are accomplishing in education and research.

These efforts are all related, and running through many of them is the thread of physical and mental restoration and rehabilitation, representing perhaps the most important challenge of all to health workers.

## COMMUNITY PREVENTIVE SERVICES

Our main public health task in Saskatchewan has been to develop new

forms in organization which will make it possible, in a democratic way, for people to obtain the full-time services of medical health officers, public health nurses, psychologists, nutritionists, sanitation counsellors, health educators, and other specialists in prevention.

We are doing this by organizing health regions. Local people cooperate financially and otherwise with the provincial Department of Public Health to set up an organization so that they can provide services, collectively, which would be unobtainable for individual towns, villages, and municipalities.

The advantages of regional organization of health services has been demonstrated on several occasions. In organized areas we have been much better able to launch effective immunization programs. This has been particularly true with respect to the Salk vaccine which, in 1955, we gave to the 4, 5, and 6-year olds as well as to pregnant women. This year all children up to age 10 will be included. In Saskatchewan the vaccine is distributed without charge by public health authorities and is given by public health nurses.

There is real promise that we shall soon bring rheumatic fever under control and even eliminate the disease as one of the important causes of heart damage. A successful prophylactic program is underway in Moose Jaw health region. There has been remarkable cooperation between the public health authorities and the local doctors. Penicillin is supplied free by the provincial health department and is given as medically required, in some instances to hold infection under control and, in other instances, to forestall complications after attacks of rheumatic fever.

There is clear evidence that infectious hepatitis is increasing in incidence throughout North America.

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Minister of Public Health for Saskatchewan, Mr. Bentley delivered this key-note address at the opening session of the 28th Biennial Meeting of the Canadian Nurses' Association.

Again, we have taken steps in an organized way to combat this disease, by making gamma globulin available without charge as medically required.

While we concern ourselves with these relatively new disease entities, we must not forget the unfinished business in continued control of those communicable diseases that have caused us so much trouble in the past. Diphtheria is not yet completely wiped out. In Saskatchewan there have been several recent cases among Indians, and some deaths. Nurses need not be reminded of the need for continued programs of immunization.

Tuberculosis is still declining and in Saskatchewan in recent years we have moved so far ahead in control that we even talk of virtual eradication. For 27 years, treatment in sanatoria has been free for all residents and for almost 20 years we have had enough sanatorium beds to ensure prompt segregation and adequate care for all infectious cases. During the last three years we have also achieved a level of sanatorium beds adequate for the Indian population. Now we can look forward to a reduction of disease and deaths among those peoples, as remarkable as we have experienced for the non-Indian population. In 1955 Saskatchewan recorded the lowest general tuberculosis death rate of any province in Canada — under 4 per 100,000.

Much remains to be done in our rural and small-town areas in environmental sanitation. Significant progress has been made recently, however, to improve housing sanitation. It is now possible for public authorities to take appropriate steps leading to the correction of substandard dwellings. As the province becomes industrialized we foresee new problems in industrial hygiene. Last year Saskatchewan was quite active in efforts to correct problems of stream pollution created by the discharge of petrochemical wastes into the North Saskatchewan River at Edmonton.

At the moment Saskatchewan is placing more emphasis than usual upon accident prevention. Specifically, we, in the health department, are directing attention to accident hazards in the home, including accidents to young children. Among those past infancy

and up to 35 years of age accidental mishaps are the chief cause of death.

The chief cause of death among infants is prematurity. Almost every hospital in Saskatchewan has been supplied with incubators. An active educational program on how to handle the prematurely-born infant is now being carried on among doctors and nurses, and special emphasis is being placed upon the proper use of oxygen to prevent blindness.

Many other causes of death, injury, sickness, and poor health among our children are preventable if knowledge of the nature of prevention is better understood and applied. We seem never to have quite enough public health nurses, whose work is basic in fostering preventive public health in the community. But the number of such nurses is growing, and the number with specialized and advanced training is also improving. We now offer postgraduate training in public health nursing at the University of Saskatchewan. Allied services by nutritionists and teacher psychologists are being expanded. We expect a great deal in the future from dental hygienists, and we are each year training several of these young women to carry out topical fluoride application procedures among children where community water fluoridation programs are not possible.

#### MENTAL HEALTH SERVICES

For many years the outlook for progress among the hospitalized mentally ill has remained one of the most discouraging problems facing health workers. Now we can report real progress. In Saskatchewan — and this may well be true elsewhere — four out of every five patients recently admitted can, within a few weeks or months, be returned to their homes in an improved condition. Hospital admissions continue high, but the overall hospital population is not increasing. Several scores of other patients, confined for years to certain wards and forgotten by the public, are now being rehabilitated to the point where they are able to take care of themselves and to take an interest in the world around them. The new tranquilizing drugs are important. More hos-



pital doors are being left unlocked. People in the community are losing their old fears and misconceptions about mental illness and about those who are mentally ill. Nursing and attendant staffs of mental hospitals are now better trained. They participate in treatment procedures with greater understanding and insight.

What has happened in the last 10 years is indeed heartening. We are curing far more patients than formerly, and slowly but surely our mental institutions are becoming imbued with a sense of hope and positive achievement.

A great many people could be helped with skilled psychiatric services if these services were available close to their homes. The Saskatchewan health department has been attempting to meet this need, and we now have three full-time well-staffed mental health clinics in our three largest cities, as well as part-time clinics in the smaller cities.

There is so much more to do, however. Overcrowding is a continuing problem and, without proper facilities, the tasks of treatment and rehabilitation are made more difficult.

Associated with the mental hospitals are the institutions for the care and training of those persons whose mental deficiency is such that they become serious problems in the community. We are quite proud of the new training school we opened near Moose Jaw last year. It is the finest institution for the mentally retarded in Canada.

As with the mentally ill more needs to be done in the community for mentally deficient persons whose condition does not warrant institutional care. There is considerable demand for more special schools and classrooms.

Before us is a tremendous opportunity for research into the nature of mental disorder. I have been most happy with the important investigations that have been going forward in Saskatchewan into the nature of schizophrenia. We know now that there are social factors operating in causation, and studies by our research teams suggest there are possible organic factors as well. If a definite causative agent can be found, we will have taken the first step in developing a curative or arresting agent.

## MEDICAL CARE AND HOSPITAL SERVICES

For a number of reasons, which are social, geographic, and economic, the province of Saskatchewan has long been a crucible where new ideas in improving the supply and quality of medical and hospital care schemes have been worked out. Municipalities have been pooling their resources since 1916 to build what we call union hospitals. Municipal prepaid medical and tax-supported care plans have been in operation for 35 years and even today, notwithstanding improved roads, the automobile, and the liking of people for big-city care, a surprising number of Saskatchewan's population — about 175,000 persons — continue to be served by their municipal doctors. These doctors serve on salary or on a modified arrangement. The municipal plans have been a most important factor in retaining the services of doctors in rural, sparsely settled communities.

The supply of doctors in Saskatchewan is not as high as in some provinces, but the number of new registrants each year compares quite favorably with other parts of Canada. The proportion of doctors who are trained specialists has, in particular, shown the most notable improvement.

The province has long been prepayment-conscious and along with the municipal doctor plans we now have prepayment plans on a voluntary basis covering perhaps another 150,000 people. The experiment in regionwide medical care prepayment, which we call the Swift Current Regional Medical Care Program, is now in its eleventh year and includes still another 50,000 persons. This tax-supported scheme has had some interesting effects beyond the removal of financial worry for payment of unexpected medical bills. The number of doctors serving the area has almost doubled. They are well paid for their services. They make much more extensive use of radiological and other diagnostic services than rural doctors elsewhere. I believe it accurate to say, also, that their interest in preventive medical care services is greater as a result of the program.

Most provinces now have organized programs of medical care for those,



like pensioners and the indigent, who receive public assistance. Our program has been in operation since 1945 and remains, I believe, the most comprehensive on the continent. We have no "class" medicine for the poor. For a cost of about \$100 a person a year to the health department, including hospitalization, these people are assured of receiving every type of medical care helpful for the restoration to health and useful lives. Other groups I should mention as eligible to receive complete treatment services without charge to themselves are cancer patients and those with post-acute paralytic poliomyelitis.

The Saskatchewan Hospital Services Plan may be familiar to you. About one person in five is now admitted to hospital every year. Admissions are free and unrestricted for all medically required hospitalization. Right now we are moving into the field of out-patient services on a similar prepaid basis. Included in the Plan's benefits this year is the free examination of out-patient tissues by hospital laboratories. As health insurance across Canada develops into a reality there is no doubt that out-patient coverage will be greatly extended.

I believe we have enough hospital beds in Saskatchewan. The level is about 50 per cent higher than the national average. The quality of hospital accommodation has been improving steadily. My department has been making construction grants available since 1945. These, along with federal grants, have helped make possible the building of many small and medium-size hospitals in communities that ordinarily could never have afforded such facilities. In a province with such a scattered population and long distances these smaller hospitals will continue to play a vital role. At the same time important progress has been made in developing large hospitals, offering of specialized facilities and services. The 525-bed University Hospital, Saskatoon, was opened in 1955 — our golden jubilee year — and is already acquiring some reputation as a centre for bed care, teaching, rehabilitation, and research.

What we are evolving in Saskatchewan is what I might call an integrated and coordinated hospital system, in

which hospitals, with regard to design and location, are of a size and function to best serve their particular communities. In this way we are placing emphasis upon improving quality while still keeping costs within limits that we can afford. Some smaller hospitals are getting together voluntarily in organizations called regional hospital councils, to pool buying of many commodities, and to obtain, for joint use, the services of administrative coordinators, pharmacists, medical social workers, and the like.

I should mention, too, the many other activities related to improvement in the quality of hospital services. The Air Ambulance Service now 10 years old, promotes regionalization. Medical audits have been instituted. We are making a study of the most effective methods of restricting elective surgery to those hospitals with adequate staff and equipment. There is work being accomplished — although it is only a beginning — by committees on how to improve standards on the use of drugs, and how to improve technical services in hospitals. Much remains to be done in bringing public health and hospital service closer together. We have made sure starts on the problem of the aged and the chronically ill in hospitals. The problem, as you know, encompasses such fields as medical social service, home care, nursing homes and homes for the aged, geriatric departments, and expanded rehabilitation services including physiotherapy.

#### EDUCATION AND RESEARCH

A noteworthy feature of modern medical and hospital care is the complexity of the organization required to make this care available where and when it is required. As a result, we need more trained people and, equally important, we need people trained in such a way that they see their special duties in a larger context of keeping people well and active.

I have mentioned some phases of the education and research programs underway in Saskatchewan. We now have one of the finest medical schools in Canada. We have a pharmacy school, and have given a great deal of thought to developing a dental school.

Continuing education is an absolute requirement for the modern physician as well as the nurse. We have been helping medical practitioners a good deal, recently, with numerous institutes in obstetrics, pediatrics, rehabilitation, cancer, and general practice.

The Centralized Training Program for nursing students is now beyond the experimental stage and we have made it an integral part of our provincial program, under the auspices of the University of Saskatchewan.

### CONCLUSION

These are some of the highlights of the organized health services in Saskatchewan. Our needs, in relation to our resources to meet them, are under

constant study by the Department of Public Health and the Health Services Planning Commission, which represents the S.R.N.A. and other professional and public bodies in the province, to advise the Minister. The trend is clearly toward making more and better health services continuously available to people, through group efforts.

This is a trend we see going on everywhere in the world, and the developments in Saskatchewan are quite an accurate reflection of Canadian and world trends. The effect of this trend is to reduce the gaps between scientific knowledge and its application in everyday life. We may never achieve that goal completely, but constantly we must strive for it.

## And the World Too

HELEN G. McARTHUR, M.A.

**I**N THE WORLD OF TODAY it is possible, as never before, to hear the voices of men call out from around the globe. Even if one does not listen carefully, it is not difficult to recognize the common cry, "Peace in our time." Modern communication forces us to hear the plea from the far corners of the globe. The plea is for freedom: freedom from war, freedom from civil commotion; freedom from quarrels and dissention between individuals; freedom from starvation and disease. The call for peace demands a time of tranquility in order that the right to an existence, worthy of a human being, may be achieved for every individual. Does nursing serve this world?

Through more than half a century nurses have built up an enviable spirit of international cooperation. They have been organized, internationally, longer

than any other professional association of women. Miss Daisy Bridges, Executive Secretary of the International Council of Nurses, has written:

The International Council of Nurses, founded in 1899, has built up bonds of friendship and fellowship among the nurses of the world which no wars or rumors can possibly sever.

Nurses have built up a strong international organizational structure, an instrument whereby action and inter-action can take place on behalf of the health of the peoples of the world and a demonstration that international solidarity can be achieved by individuals with humanitarian motives. What is it that has enabled the nursing profession to achieve this record when, on every hand, we see so little progress by those who function in the arena of international diplomacy? To protect myself from the accusation of undue prejudice I would quote Prof. F. N. Salter, speaking at the 1954 Biennial Meeting of the Canadian Nurses' Association:

What is it that has enabled the nursing profession, in one brief century, to achieve so dazzling, so tremendous, and so inspiring a record? Nothing but the most commonplace, natural and human

Miss McArthur had a most stimulating eighteen months in Korea with the International Red Cross. Returned now to her post as Director of Nursing Service with the Canadian Red Cross Society, Miss McArthur gave the closing address at the recent CNA Convention.



of all things — love. The nurse does not ask what character the patient may be: he may be utterly depraved and wicked — or he may be saintly, wise and brilliant; but the nurse is neither his maker, nor his judge. His skin may be red or white or yellow or black. He may be Jewish, Christian, Mohammedan, Buddhist, or atheist. The nurse does not concern herself with these impertinences; the patient needs her ministrations and the patient receives them—generously, and in full measure. Nursing, in short, is practical democracy; it is democracy in action; it is a living example of that ancient gospel: Love thy neighbor as thyself.

The nurses of the world have taken this personal philosophy beyond the bonds of home, community and nations, beyond the frustrations of language and the conflicts of political ideologies and made it work in the international scene. It was my privilege to witness the true significance of the international implications of nursing during my period of service in Korea. Until recent years, this little known country has sought safety in isolation, developing unique customs and a distinctive way of life. This independence was shattered about the end of the nineteenth century by violent occupations followed by the recent devastating war. Korea, thrust into a position of international significance, became the stage on which was played a mighty demonstration of international action for a free world.

I could actually see with my own eyes, no abstract philosophy of hope but the reality of nations of the world at work together, through military aid and civil assistance. There were members of the Armed Forces from the United States, Turkey, the Commonwealth, Ethiopia, France, Greece, for example, not long ago having fought together, now living together, planning and training together, alongside the Koreans, all with the common purpose — the protection of the free world.

There was an impressive band of civilians, under the United Nations Command, at hand to aid in the reconstruction of Korea following the devastation of a United Nations war. Throughout the land, it was possible to see the components of health teams

from as many countries as there were individuals, with Korean counterparts, planning and working together for the benefit of the health of the nation. The Canadians were few but mighty: Mr. George Hall, the Assistant Agent General of United Nations Korean Reconstruction Agency; King Gordon, Public Relations Director for the United Nations; Ken Marshall, Secretary of the Korean Association of Voluntary Agencies, the only staff member coordinating about 50 voluntary agencies from around the world, and Dr. Richard Brown, Chief of Preventive Medicine for the Korean Civil Assistance Command, to name a few. Then, too, numerous missionaries with a long and respected history of bringing succor and faith to the people of this land were working together with a new spirit of internationalism.

No finer example of international cooperation and action could be found than that demonstrated by the nurses. I was never prouder of my profession than when I attended my first meeting of what was called the United Nations Nurses' Association in Korea. Usually, about 50 nurses managed to gather from the four corners of South Korea, travelling by crowded train, military plane, army jeep or truck, to share their experiences and resources for the benefit of Korean nursing. They were joined by gallant Korean nurses, who were struggling to raise the status of nursing in a situation where the standards of nursing care and nursing education are in a very early stage of development; where doctors outnumber nurses 3 to 1; where hundreds of nurses were killed or kidnapped in the war, leaving a total of just over 2,000 nurses, scarcely 1 — 10,000 people (shortage of nurses indeed!).

The Korean nurses eagerly grasped the opportunity to discuss their problems with these outsiders: military nurses from the United States and the Commonwealth; Red Cross nurses sent by their respective governments of Sweden, Italy, Germany and Switzerland, or by the Red Cross societies of Britain, Belgium and Canada; Danish nurses who stayed ashore from the hospital ship "Jutlandia" after hostilities, to help in the reconstruction of health services, alongside United Nations nurses from Sweden, Norway,



the Netherlands, United States of America and others under the leadership of Miss Susan Haines of Australia; missionary nurses from many lands and of many faiths, including Canadian nurses who readily served as Korean interpreters because of their long service in Korea, such as Ada Sandell, whose letters may be read in *The Canadian Nurse*, and Beulah Bournes working in Severance Hospital, noted as the first modern school of nursing, opened in Korea by Canadian missionaries a bare half-century ago.

In turn, Korean nurses had much to offer their confreres who came to work with them. They demonstrated courage and fortitude in the face of overpowering odds: that pettiness has no place in the midst of problems of great human suffering; that smiles and songs are mighty weapons against hunger, cold and fatigue; that good nursing does not entirely depend on plumbing, electric lights, Gatch beds or complicated equipment.

At such a time, and in such a situation, it is possible to feel the mighty impact of nursing on the international scene. Though caught in an uneasy world filled with fear of war and international tensions, nurses managed, by their concern for human need, to give a stabilizing influence that brought a ray of hope for the future of mankind.

Do I hear you say, "That's all very well for the few nurses who are given the opportunity to work in other lands and participate in these fascinating international operations. But how can I serve the world when I'm tied to this patient, this hospital or this community?" This international experience away from my own country has only served to convince me that the greatest contribution any one nurse can make, within the limits of her knowledge, preparation and resources is in her own local situation; to serve her patient, her hospital or her community at home in such a way that it will stand as a shining example of good nursing and be so good that the example cannot be ignored but will be shouted from the hilltops and so resound around the world. Nursing care must be so good that others will want to copy the pattern as it can be

fitted to the cloth in their situation.

Such a contribution has a value above all others and the effect is twofold. The contribution of the one nurse assures the best service at home and at the same time, when copied abroad, becomes the contribution of many, all content because the garment fits. There is no need to worry about language barriers, differences in cultural patterns, for each may copy and adapt according to the needs and resources of their own country. From the basic example may come an infinite variety of good nursing care having all that we admire in the beauty of a mosaic.

Canadian nurses should be particularly fitted for this type of international contribution. Did not the early pioneers of Canada create the patchwork quilt? It seems to me the means whereby nursing serves the world is very much the same as the old-fashioned quilting bee. Individuals pool their time and materials, work together, each taking responsibility for the worth of her own section, but recognizing the over-all pattern and the necessity of maintaining a standard of workmanship; frequently exchanging ideas and colors so that the finished product is beautiful to see and a comfort to the recipient. Then, too, there are so many side-products of the quilting bee: friendship, understanding and true charity.

I would be the last to belittle the need for well prepared, experienced nurses to offer their services to international agencies such as the World Health Organization or the Colombo Plan. Canadian nurses can take great pride in the fact that the Chief Nurse with the World Health Organization, Miss Lyle Creelman, is a Canadian and that many Canadian nurses are serving in far-flung lands. We know that Miss Creelman is always searching for more nurses, with special preparation in teaching and public health particularly; with additional languages, hopefully. But I emphasize again that their contribution is only fruitful when backed by the best there is in nursing at home. *The Canadian Nurse* is frequently the best example of Canadian nursing foreign service as it tells of good nursing in Canada and is well read by nurses abroad.

However, the International Council

of Nurses provides the major body through which we may all contribute. Will international nursing be as strong, as frugal and as wise in the future as in the past? Will the result bring comfort and happiness to the people of the world? The answers to these questions depend on the individual nurse. May the Canadian patches of service bring honor to this nation and fulfil the purpose of the International Council of Nurses as enunciated in the Preamble to the Constitution and By-Laws,

We, nurses, representing various nations of the world, sincerely believing that the profession of nursing will be

advanced by greater unity of thought, sympathy and purpose, do hereby unite in a federation of national associations of nurses. Such national associations shall be non-political, shall embrace all religious faith, and shall work together for the purpose of nursing care of the sick, advancing the professional and economic welfare of nurses and enhancing the honor of the nursing profession.

Thus, as Canadian nursing serves our nation, and the world too, may it become an example so challenging that it will be emulated and provide an effective answer to the cry — "Peace in our Time."

## Student Day Activities

EDYTHE WILDFANG

**T**UESDAY, JUNE 26, was Students' Day at the Convention. The Day commenced at 9:00 a.m. in the Arts Building when students were welcomed by Miss Sheila Nixon on behalf of the national association, and by the author on behalf of the students of Saskatchewan and Manitoba.

The students were in uniform for the morning session. There was great interest displayed in the various uniforms, caps, shoes and stockings and pins. The uniforms seemed to create a bond of friendship immediately.

The opening session was in the form of a panel presentation — the topic being "What the Future Holds." This was a fitting topic since the theme of the convention was "Nursing serves the Nation." The nursing students of today will be the nurses of the future. Our pledge of rendering service means that it must be available to the rich and the poor; the city dweller, the mine worker, and the farmer; in hospitals and at home; in industries and in schools. Since nursing service, then, must be given in such a variety of places and situations, and so many types of service are needed, it seems wise that, when nursing students have graduated, they should further prepare

themselves to function more adequately in the situation in which they feel they can serve best. This is the justification for providing special courses for graduate nurses in universities and hospitals.

The students on the panel were: Margaret Drew, Toronto General Hospital, who spoke to us about courses in public health nursing; Georgina Savage, Saskatoon City Hospital, who told us about courses in teaching and supervision in schools of nursing; Fay McDowell, Royal Victoria Hospital, Montreal who described courses in obstetric and pediatric nursing; Alma Hammer, Vancouver General Hospital, whose topics included Psychiatric and Tuberculosis Nursing, and also operating room technique. Each of them gave us specific information as to where the courses are available, qualifications necessary, the cost and length of the courses, and positions available after completion of these studies.

A question period followed the panel presentation. This was a very lively session. The students displayed extreme interest in the information that had been presented. They participated actively by asking questions and by giving information about their own hospitals. Miss Margaret Hart, director of Nursing Education at the University of Manitoba, was present at

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Miss Wildfang is the immediate past president of the Manitoba Student Nurses' Association.



the meeting to answer those questions which the panel members felt they could not answer adequately.

At 11:00 o'clock 10 groups, each made up of 15 to 18 students, convened in separate rooms for "buzz sessions." The buzz session topics were as follows:

- State board examinations.
- Interest in student activities.
- Professional etiquette in hospital.
- Block system of lectures.
- Psychiatric nursing experience for students.
- Student Nurses' Associations, local, provincial.
- Student responsibilities on the ward.
- Team nursing.
- The nursing student receives her cap.
- Student government.

The members of each group expressed their opinions with clarity and freedom. It is felt that this sharing of thinking will be of benefit to all.

Following the buzz sessions, buses conveyed the students downtown to the Club Morocco, where a luncheon was served. Members of the CNA Executive Committee were entertained. Grace was said by Mary Betton, from Royal Alexandra Hospital, Edmonton, and a toast to the Queen was proposed by Barbara Brown, from St. John's General Hospital, Newfoundland.

Reports from the buzz sessions were given after the luncheon. They indicated that the thinking of the students is very keen in all aspects of professional nursing activities. Highlights from these reports included the following opinions and feelings:

1. It would be desirable to have a Standard Canadian Curriculum for schools of nursing since the Canadian provinces will probably soon all be using standard written examinations. It would also be desirable for us to have examinations set up by a Canadian Board rather than to use the National League for Nursing Test Pool examinations. The students feel that a Canadian Board would set examination problems that are more applicable to our situation.

2. The "nursing team" method is usable, with modifications, in both large and small institutions. It was felt that this method makes it possible for the nurse to get to know the patients better than with the functional method. The patients would also get to know their

nurses better. The opinion was that in team nursing the complete ward staff could be used to the fullest extent.

3. The nurse's cap should be given *at the end of the preclinical period*. It signifies official acceptance into the school of nursing and gives the student a feeling of security. It also gives the feeling of finally having been given responsibility in her chosen profession. A national cap is not desirable.

4. The opinion as to when psychiatric nursing experience should be given was divided. Some of the members felt that it should be given early in the nursing course because it would be beneficial in the management of all types of patients with difficult behavior. Others felt that it would be easier for the student if given later in the course because all the basic instruction is given early.

5. Students should have a variety of interests outside of nursing. One of these interests should be in church affiliation. In order to create an interest in student activities there must be good leadership which can come from either senior or junior students. There must also be good publicity to produce effective events.

6. The student nurse's responsibility on the ward begins the first day she is in the hospital situation.

7. The students, generally, felt that there is better response to student government than to regulations made from the director's office. There should be staff representation at executive meetings of the student council.

At the completion of the reports Miss Sharpe spoke briefly to the students commending them on their good thinking and expressing the conviction that nursing in the future would be in safe hands. She also expressed the hope that the students would carry their enthusiasm on into the days to come, and in 10 or 15 years they would be working with and perhaps solving some of the problems of which they spoke now.

In closing I wish to express, on behalf of all the students our sincere appreciation to you, our "Big Sisters." We consider it a great privilege to be able to attend the biennial convention, and we are grateful for the recognition which we receive. We trust that we will not "let you down." We want you to be proud of us now and in the future.



# Changing Attitudes

ELISABETH C. PHILLIPS, B.S., M.A.

IT IS UNFORTUNATELY TRUE that many nursing as well as medical students are only happy so long as they have *interesting* people to care for. Too often they define interesting as meaning persons who are acutely ill. They lose interest when they are expected to care for chronically ill patients. Not only do they lose interest, but they very often look down their noses at those who do care for patients with long-term illness and they say, "Anybody can give that type of care. Anybody can care for old chronics."

Nor is this attitude of disinterest confined to student nurses — graduates as well either have little interest in this type of patient or they actually resist this type of nursing. Their eyes light up, their heads and minds respond only when giving care to the unusual, the very dramatic, the acutely ill, or the person in the acute situation. There has, of course, been one exception to this. Some are genuinely interested in children who have a long-term illness, but even here they probably have experienced boredom as they were required to give care to youngsters with some sorts of afflictions, such as eczema.

Of course these attitudes are often shared by all members of the patient-care team but nurses are in the majority when they feel that care of the chronically ill is something with which they should not be personally concerned. Being in the majority is a comfortable place for nurses to be, but should we stay there? Why can't all nurses join the fringe of some other disciplines made up of those people who have acquired, by hook or by crook, a keen insight into the needs of the chronically ill and who are determined to help meet these needs in a dynamic fashion?

Perhaps our curricula for nurses, both basic and advanced, need a re-

view in order to see why this belittling of chronic disease care exists. Nor must our examination be limited to what teaching goes on in the classroom. Attitudes are learned far more rapidly in on-the-job situations than they are in the lecture room. Therefore, the challenge to in-service education of those with whom students work is immense.

In my work as the director of a visiting nurse service, I have become accustomed to student nurses saying during their affiliations with us, "Why do I have to care for these old chronics? I would like to have some interesting cases for a change." Such remarks have come to be a commonplace, unfortunately, but it still comes as a shock to me when a director of a school of nursing points out, with every indication of dissatisfaction, the fact that she would like her students to have experience caring for acutely ill patients in their own homes and not for "old chronics." "Students need interesting cases, you know, in order that they will learn," they say. This is the sort of comment that upsets me no end.

Why, I ask you, can't students "learn" (whatever that is) when their patient has a chronic illness? Until comparatively recently we probably have had too little to teach students under these circumstances, but that most certainly is not true today. There is a body of knowledge, attitudes and skills that we must master and then pass on to our younger generation. Something must be done so that the outgrowth of our educational system in nursing does not foster derogatory and belittling attitudes towards the chronically ill.

We need to have a much more constructive viewpoint in this whole matter. Emphasis on frustration and discouragement in tackling these problems must be left behind. Much, very much, can be done and nurses have a vital role to play in doing it. Carlysle Jacobsen, Executive Dean of

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Miss Phillips is Executive Director, Visiting Nurse Service of Rochester and Monroe County, New York. This is the third in her series of articles.

Medical Education in the University of the State of New York, has said, "Special nursing for the chronically ill may become one of the most important factors in successful rehabilitation."

It is imperative for all persons — those working with the chronically ill, the chronically ill themselves and those who are likely to become chronically ill at some later date — to face intimately their own attitudes and feelings towards disability and illness. As long as underlying devaluation attitudes exist, behavior which devaluates will follow in its wake, even though it might have to cloak itself in a guise of innocuous expediency.

In the modern health care picture, the chronically ill person is often, although not always, judged to be inferior to those acutely ill; that is, he is of a lower status than is the one who is acutely ill and also lower than we who are attempting to give him care. He is looked down upon and pitied because we think that dependency and helplessness are devaluating characteristics. We harbor such thoughts as "I'm glad I'm not like you." We treat him as an object of sympathy, not with the respect due him as a human being. We do things *to* him and not *with* him; we neglect to ask his opinion or find out his feelings; we turn a deaf ear when he tries to tell us about his problems. All of this tends to make us leave him out of major decisions relating to his own care. We say — "We don't want to bother the patient" or "he wouldn't understand anyway." Then after the decisions have been made and a plan set up for him, we condescendingly expect him to accept it wholeheartedly. If he doesn't we become annoyed and give him that worst of all labels, "uncooperative." In doing all this, we are treating him like a child, we tell him what is best for him. what he may or may not do, we scold him or we cajole him. It is any wonder that he exhibits childish behavior in return?

In an article published in *Social Case Work* and entitled "Social Work and Human Problems," Smithin Bowers has identified four fundamental principles of case work. These four principles are equally applicable to the work of nurses who are caring for the

chronically ill. First, there is the *principle of self-determination*.

Social work has applied, in a concrete fashion, the principle that the human being can obtain his own perfection only through the exercise of his free will, that he has both the right and the need to be free in his traces.

Second, the *principle of particularization*.

Human problems do not exist in and of themselves, but rather in persons who are individuals with their own personal unicity; and understanding of a problem is related to our identification of the specific differences within this particular person, this particular group, or this particular community.

Third, the *principle of acceptance*.

This principle implies that social workers must perceive, acknowledge, receive and establish a relationship with the individual client as he actually is, not as we wish him to be or think he should be.

Lastly, the *principle of relationship*.

The effective medium of help for the client lies in the dynamic interplay between the person of the worker and the person of the client, an interpersonal process that should be related solely to meeting the needs of one party to the relationship.

These processes operate in all of our contacts with all of our patients, but they are particularly important in our relationships with those with long-term illnesses.

The devaluation attitudes that society has towards the chronically ill are exactly the same as those he has toward himself. He believes that his illness lowers his prestige with others as, indeed, it does seem to do. He believes himself to be of lesser status than he was before he became a chronic invalid and this total self-devaluation process is painful in the extreme.

It is, therefore, important for us to understand and to help others to understand that these feelings exist and that we, who give him care, must not do anything to increase them. For instance, if we do something for him that he is capable of doing for himself, we are increasing his feeling of inadequacy. Our actions should be directed towards helping him to take on more responsibility for himself — in little ways as well as larger ones. We



want to make him believe that he is capable of making decisions just as soundly as he was able to before he became ill. He is going to need much more help in order to see those problems in a light that will make possible adequate solutions, but it should be, in the end, *his* decision, not ours.

Too often nursing is still based on the old concept of care that kept patients in bed not for days, but for weeks and months. During that time an intimate relationship was developed between the nurse and the patient that is threatened today as we try to make the patient independent of us. Nurses got much personal satisfaction from this old relationship, dominated by concern for doing *for* the patient. Perhaps one reason why nursing services are so pressed today is that we are clinging to our old goals of patient care that seemed to serve so well in the leisurely, and comparatively simple, old days. Now these goals create a decided conflict in the midst of the confused, complex, short-staffed situations in which we are working. It is not that the quality of our goals has been lowered, but that they have been changed — for the better, we believe. Today, the aim of helping the patient to help himself is a dominating component.

All of us, whether we are working in hospitals, public health agencies, industries, or schools, are struggling with the task of providing the quantity of nursing service needed to balance the ever-increasing demands for care of patients of all types — including those with long-term illnesses. At the same time we are struggling to provide *quality* of care for these people. To do both is the dilemma that confronts us.

Marion W. Sheahan has written in her foreword to "Society and Health" by Walter E. Boek and Jean Cable:

There is growing awareness that the improvement of quality rests, not so much on the technical aspects of patient care, but upon its social and emotional aspects and the relationship among the workers who provide the care. As this awareness has grown, it was inevitable . . . that doctors, nurses, dentists and social workers turn to social science for help in analyzing problems and in gaining insight for new relationships

with patients and among themselves as allied professional groups.

One of the changes in attitudes which we need to make today is in our definition of *kindliness* to patients. Is it kind, for instance, to make an arthritis patient learn to put on his own stockings when he has great difficulty in bending and may have to use a special gadget to bridge the distance between foot and hand? Intellectually we may accept the need to have the patient master this aspect of daily living, but we don't seem to be able to accept it in our own hearts. We don't think it is being kind to him. We want to do it for him (and sometimes we revert to that very thing even when we know we shouldn't). In other words, it disturbs us not to do *for* patients, it disturbs us to help patients to do for *themselves*. The lay public has this same attitude.

There is need for changing our attitudes along another line. Many of the younger physicians are now ready to accept a new relationship with nurses and give them a more important role in the planning and supervisory aspects of medical care. More and more often opportunities are arising for nurses to participate in interdisciplinary patient care conferences. But too many times the nurse feels that she must "keep her place" though by so doing, she eliminates the very real possibilities that she may contribute to the planning as well as to the execution phase of patient care. It is imperative that we teach the oncoming generations of nurses that they can and should participate in conferences "at the summit" and furthermore, we must help them to be able to do so effectively.

We need to change our attitudes in yet another way. Because of the heritage of the intimate relationship between patient and nurse, we sometimes find it difficult to accept the fact that others are now going to be on an equally intimate footing with the patient. Our resentment rises, for instance, when a practical nurse or a nursing aide seems to understand a patient's needs better than we do ourselves and when the patient asks for that person to help him with problems. We are even upset when we hear such an auxiliary worker refer to the pa-



tient as "my patient." This is another attitude that we need to change, so that we will want to work *through* others to the patient as well as to give him direct care ourselves. To know when to do one and when to do the other calls for sound judgment and this, too, is something that we must develop among nurses.

Change is inevitable, but the speed or slowness with which it comes *can* be controlled. Change is a characteristic of life in any country that is based upon the democratic principles that make it possible for small groups of people to share their ideas with others. The changes instigated by these small groups may, of course, be rejected or they may be gradually or speedily accepted and so become a part of the community-wide behavior.

When we look at the social structure of our community, it is regrettably evident that many leaders in the overall social system are interested in

maintaining the status quo. This is particularly true in nursing. Our present-day leaders resent change because the status quo gives them security and change is always a disturbing factor, at least in the beginning. Our ways of doing and thinking are protected from the searchlights sometimes turned on them to good advantage by the small groups of thinking pioneers, but that does not mean that the searchlight is not needed.

Medicine is conservative — it always has been and probably always will be and rightly so — but medicine does change and never more rapidly than in the past 25 years. Let us be sure that nursing — both nursing skills and nursing attitudes — does not lag behind. We do not, of course, desire change for change's sake; on the other hand, we must not be afraid of change when, in the light of our present-day standards and goals, it seems to be desirable.

## In the Good Old Days

(*The Canadian Nurse* — SEPTEMBER, 1916)

No editor can make a professional journal out of thin air. Do you suppose she enjoys printing warmed over graduation addresses, full of anemic platitudes? She does not! She only does it because she has vainly canvassed every nurse she can think of, only to be assured with a bashful smile that "she really couldn't think of appearing in print." Justly or not, there is a tendency to look upon those whose names appear as the authors of articles as self-advertisers, eager for notoriety. This most unjust aspersion has worked incalculable harm to our journal.

If our journal is not all we should like to see it, then the fault is our own. It is our lethargy and indifference that have militated against its success.

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Repeatedly letters of protest and, on two

occasions, delegations of trained nurses have interviewed Sir Robert Borden, the prime minister, regarding the numerous instances of untrained women being enlisted in the C.A.M.C. as nursing sisters. These protests have largely gone unanswered.

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The Alberta Association of Graduate Nurses is glad to be able to report that at the last session of the provincial legislature the first Registration Act was passed.

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Of 93 hospitals replying to a questionnaire regarding training schools for nurses, six had full-time instructors. The educational requirements for admission to training were varied: High school entrance, 37; one year high school, 25; two years high school, 8; not stated, 23.

Exercise rather than bed rest is being prescribed for patients with varicose ulcers on their legs, at an American clinic. The therapeutic technique employed is described as "elastic adhesive ambulatory compression." Application of an elastic bandage,

active use of the legs and no medication form the treatment. The bandaging reduces the edema and allows normal physiologic repair while the exercise prevents the recurrence of edema.

— *Scope Weekly*

# Glomerulonephritis

SISTER MARY DORIS

THE DISPOSAL OF WASTE is an essential in the promotion and maintenance of health. In terms of the physical world, we depend on the proper functioning of an adequate sewage and garbage disposal system. Our bodies are dependent largely upon a healthy urinary system. When a breakdown in the waste disposal system occurs, then you have disease conditions resulting. What happens when the human system becomes defective is poignantly illustrated by the story of Douglas.

The eldest of a family of three, Douglas was a well-adjusted, cooperative, intelligent little boy. His parents were of moderate means and had provided a happy home environment for their children. The medical history of the entire family was essentially negative for illness. The parents could not recall any instance of kidney disease in either of their respective families. Each baby had been the result of a normal full-term pregnancy. All had been healthy and vigorous with no congenital defects.

Douglas' first admission to hospital was in March, 1951 when he was four years old. On examination he was seen to be rather small for his age and very pale. He had had one attack of *otitis media* and was subject to frequent sore throats and colds. A routine urinalysis was done which, at that time, showed no evidence of kidney damage. A tonsillectomy was performed and after an uneventful recovery, the little boy was discharged.

In November, 1952 Douglas was again admitted to hospital — this time with a diagnosis of *cystitis* and *fibrositis* of the neck. He showed slight puffiness around the eyes and his hands tended to swell although there was no edema of the extremities. He had also developed *emuresis*. This time the urinalysis report indicated the presence of albumin

and some blood and pus cells. Four days later the albumin content had increased noticeably. There were no casts present in either specimen. *Nephritis* was considered as a possible diagnosis but, as the *fibrositis* had cleared satisfactorily, Douglas was allowed to go home. There, he was kept under further medical observation.

In December, 1952 the child returned to hospital acutely ill. He was pale, listless and complaining of recurring frontal headaches. He was still troubled with frequent sore throats. The urine was a dark smoky color and Douglas suffered from nocturia. Although ascites was not present, there was obvious edema of the face and hands. He ran an intermittently high fever.

Numerous laboratory tests were carried out. A non-protein nitrogenous estimation was done and found to be within normal limits (31 mgm.%). A red cell count indicated a mild degree of anemia. The urinalysis gave the only real clue to the cause of the illness — albumin and casts were both present. A diagnosis of second stage *nephritis* with *nephrosis* was made. Douglas was placed under observation and a careful medical regime instituted.

## MEDICAL CARE

*Complete bed rest.* This was essential in order to put the kidneys at rest and so reduce edema.

*Careful estimation of intake and output* to help determine the extent of kidney function.

*Restriction of fluids* to 500 cc. daily. This aided in decreasing edema and reduced the workload of the kidneys.

*Blood pressure readings* twice daily. Excess abdominal and tissue fluid causes pressure on vital organs and their blood supply resulting in hypertension.

*Weight* obtained every second day. This helped to show variations in edema.

*A large chest plate:* Pulmonary edema is a possible complication.

*Flat plate of abdomen:* This x-ray is done to demonstrate the presence of fluid in the peritoneal cavity or to show any

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Sister Mary Doris, a student at St. Joseph's Hospital, Victoria, B.C., received honorable mention for this study in the Macmillan award competition for nursing care studies.



density that could result from a tumor or stones within the abdominal cavity or urinary system.

*Blood electrolyte estimations:* The great loss of fluid from the blood into the tissues increases the concentration of the blood constituents. The delicate balance between acid and base is lost. Douglas had been placed on cortisone therapy — a substance which tends to produce sodium depletion and potassium retention. Electrolyte estimation helped to check the development of this.

*Frequent urinalysis:* This served to indicate the extent of kidney damage and aided greatly in following the progress of the disease.

*Cortisone therapy:* A non-specific use of the hormone which tends to produce striking improvement in inflammatory conditions of various kinds.

*High protein diet:* This compensated for the protein being excreted in the urine and maintained normal blood viscosity.

### NURSING CARE

The usual picture of this condition is to have an acute phase followed by a chronic phase. The nursing care needed varies with the physical condition of the patient. The important principles observed in caring for Douglas are contained in the following outline:

#### *Physical care:*

1. *Careful charting of intake and output:* The doctor's orders varied with this record and accurate estimation was extremely important. Intake included fluids taken by mouth and parenterally; output included a record of severe perspiration, diarrhea and vomiting as well as urine excretion.

2. *Skin care:* This became particularly significant when edema was present. Under edematous conditions, the skin is very sensitive to pressure, circulation is poor and break down can occur very readily while tissue repair is greatly hindered.

3. *Oral care:* This was very essential at all times. Douglas was highly susceptible to upper respiratory and other infections. When vomiting was severe, the value of oral care as a comfort measure could not be over-estimated.

4. *Avoidance of constipation:* There was a tendency for this condition to develop. In caring for Douglas it was found most helpful to have a regular period for defecation established.

5. *Oxygen therapy by tent:* This was used in the latter stages of the disease to facilitate breathing. At that time Douglas showed evidence of pulmonary edema with labored, rapid respirations, 40-50 per minute. The nurse was responsible for instituting the therapy when needed, as quickly as possible and also checked the equipment periodically to be sure the oxygen supply was adequate and the temperature in the tent comfortable.

6. *Ensuring adequate rest,* avoiding chilling from draughts and protecting the patient from exposure to other infections were equally important. Worthy of special note is the fact that a nurse with a cold should not care for a patient with nephritis.

### MENTAL CARE

Physical care while of utmost importance, is not enough in itself. One of the greatest problems in caring for Douglas during the chronic stages of his illness was to keep him mentally comfortable and happy. He had an active, inquisitive mind and a small boy's natural dislike of staying in bed for long periods. Rest was essential and entertainment had to be free from much exertion. Coloring books, cutouts, guessing games, stories, building small models of houses, barns and fences with toothpicks and glue provided many hours of quiet, educational amusement.

Through the companionship and gentle discipline of his parents and nurses, Douglas was made to feel secure and necessary. He was taught the simple lessons of honesty and good manners. Although it was recognized that his lifespan would be short, Douglas was helped to live as fully as possible within his limitations. Stress was placed on the necessity for not treating him as an invalid either while in hospital or during his visits to his home.

### PATIENT TEACHING

In order to help him attain the greatest degree of health possible, Douglas was encouraged to continue practising faithfully the fundamentals of health already begun in his home.

1. Dental care at least twice a day.

2. The importance of proper clothing and footwear when out-of-doors. Avoidance of chilling from drafts and wet clothing.

3. Cleanliness.



During the period December, 1952 to September, 1954 Douglas was in and out of hospital several times. Each time he returned it could be seen that his condition was noticeably deteriorating. The urinalysis reports invariably showed albumin and casts. Blood proteins continued to become lower.

Edema of the lower extremities developed as well as of the face and hands. Ascites became very pronounced and paracentesis was done frequently to help relieve the discomfort. As much as 800 cc. of ascitic fluid was removed every second week. Douglas' blood pressure varied from 120/94 to 176/120. His weight showed a variation of 4-5 pounds over a 2-day period. His skin was dry and his hair scanty and very coarse. Due to the edema his pallor

became very pronounced. Frontal headaches were common and as time went on uremia became an added, albeit not unexpected complication.

On his last admission for hospital care, Douglas had a blood pressure of 190/130. Pulmonary edema was present and his respirations were labored and rapid. Oxygen and aminophylline relieved the respiratory distress temporarily but the child's condition continued to deteriorate and he died in September, 1954 at 7½ years of age.

#### SUMMARY

The symptoms and clinical findings exhibited by this little patient presented the classical picture of glomerulonephritis. Douglas succumbed to complications of the disease.

## Common Sense Safety Precautions

Safety rules might be repeated a thousand times over, but every summer hundreds of children become unwilling statistics in the records of those who are crippled. Perhaps the only way to strike back lies in the hope that repetition will make everyone safety conscious. Safety measures to be observed in the home, on the highway and out of doors include:

#### *For parents:*

Set an example for children. Take advantage of any opportunity to teach safety measures.

Guard young children from crippling or fatal injuries by using common sense protection. Keep guards around stairs, windows and backyard ponds, pools, cisterns or wells.

Don't let garages become storehouses of death for children. Store poisons such as insecticides, paint removers and thinners safely and out of reach. Do the same with fireworks, firearms and other explosives.

Clean up backyards, removing nails, broken boxes, boards and glass. Make sure clotheslines are strung high. Keep playground equipment in good repair.

Supervise burning of rubbish, and do it on a windless day.

#### *For children:*

Remember safety rules learned at school, and practise them.

\* \* \*

In the training of children, the pronoun to be used by either parent is *we* — rarely if ever, *I*.

Join a community class in swimming and follow the safety precautions. Wait for an hour after eating before going into the water. Don't swim too far, alone or in unfamiliar areas.

Be prepared on hikes, fishing trips and boat rides. Listen to leaders' directions and follow their examples.

Keep away from unauthorized areas like ditches, excavations, dumps or junkyards. Don't play around with farm machinery.

Be careful on the street. It's not a playground. Walk with the green light and cross at the corner.

Keep bicycles in good repair. Don't do stunts on bikes. Show-offs aren't funny.

#### *For the community when driving:*

Treat youngsters as if they were your own. Obey all traffic signals and signs. Slow down in play areas. Watch for the unexpected dash into the street.

Give cars complete check-ups before venturing to the highway. Make sure tires, brakes, lights, steering wheels and batteries are in top shape. Take along emergency supplies.

Don't drive too long on vacation trips. Stop before fatigue sets in. And don't drive too fast.

— NATIONAL SOCIETY FOR CRIPPLED CHILDREN AND ADULTS

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What really flatters a man is that you think him worth flattering.

— G. B. SHAW

# Life, Profession and School

SIR FRED CLARKE

(Concluded from August, 1956)

So much then, at least for the present, for the all-important foundations. What of the special vocational superstructure, the training of the nurse as such?

Here you have for guidance the rich resources of the Survey Report, so I need do no more than touch upon some of the main considerations. I will speak first, briefly, on the social implications, and then, at somewhat greater length, of the Educational necessities.

Concerning the relation of the nursing function to the structure and functioning of society as a whole, I wish to say quite definitely that I see no hope of a final and satisfying solution of the problem of training unless the health services of the community are de-commercialized. The problem is simply insoluble unless this is done. I have often noticed the curious fact that debates on professional questions — even among teachers and professors — frequently turn out to be, in reality, just conflicts of vested interest. So long as the commercialized competitive basis persists, so long will the human and social value that should dominate training tend to be vitiated at their source. Even if the instructor sees straight, the pupil will be tempted to look askint. The universities themselves are not free from it either, unless we are to believe that every Ph.D. degree is sought with a single eye to the advancement of learning. I know nothing more melancholy in a teacher's life than the watching of this "contagion of the world's slow stain" as it creeps insidiously but deliberately over pupils in whom he thought he had seen capacity to resist. The evil is only made worse by hypocritical unctious about "service."

It is not for me to say how the socialization should be effected. I merely lay down the principle as necessary to a full and worthy achievement of the educational end. But I would like

to add just a word about the alleged "loss of the spur of competition" that would follow upon socialization. This contention impresses me as a melancholy instance of our customary failure to think comprehensively and disinterestedly on those great social issues. Two things can be said about it. In the first place, to *what* kind of competition is the present order of things a spur, competition for the advancement of professional practice or competition for the material advancement of individuals? Some material for an answer might be had from an inquiry into the sources of advancement in medical and health practice during the past century or so. How many of the advances have originated with purely "competitive" practitioners?

In the second place, would there be no competition under a socialized system? The question answers itself. But, of course, it would be competition of a different kind.

Really I am more than sceptical about this argument of "competition" in the 19th century economic form in which it is usually put. At times it almost seems to be equivalent to an assertion that the human aspiration towards excellence will not function at all except at the lure of gold. Yet all experience of genuine human service belies it.

I turn now to speak more specifically of the scheme of training that is implied by our double objective of a vocational adaptation growing out of a live and strong general culture.

The Survey Report in the comprehensiveness of its range over the whole field reminds me a little of the famous "Institutio Oratoria" of Quintilian where he discusses the training of the orator. He begins by getting his subject satisfactorily born, and does not think it irrelevant or unseemly to discuss the details of the regimen of infancy. For it all belongs, since "Ora-



tor nisi vir bonus, non potest." The Survey seems to think much the same about nurses. True, they have to be made as well as born, but the making goes on from the first and there are certainly some who are born *not* to be nurses.

Again, note the *representativeness* of this matter of the education of the nurses. It is one well-marked instance of the whole general process, and the Survey is entirely right in bringing to bear upon the problem wherever it can, the best of our ascertained knowledge about the educative process.

You will not expect me to discuss the infancy regimen of the embryo nurse as Quintilian discusses that of the embryo orator. But it is not irrelevant, and as a father of five daughters I might claim to have a few ideas about it.

However, I must concern myself here with the more strictly scholastic preparation. The field can be divided conveniently into three parts or stages. The first I will call "Cultural Saturation"; the second "Specialization"; and the third, "The Higher Training."

What I mean by "Cultural Saturation" should now be sufficiently clear. I will not call it the dipping or dyeing process as that makes the subject of it too passive. But it is something of that sort in its effect. What it does is to produce the live, alert, self-conscious *type* of a culture, which, if not yet fully developed, is full of the promise of rich and many-sided development. Of course, in Canada, the cultural constituents will have their Canadian flavor, but I see no serious danger in Canada of a narrowly interpreted Nationalism restricting the possibilities of a broad human culture. The charge is rather the other way: incoherence and shapelessness and lack of a clearly defined sense of what it means, culturally, to be Canadian. But a touch of adversity seems to have made the omens more favorable and there are welcome signs that the whole common life of Canada may draw itself together in a more self-conscious unity, fruitful in suggestion and guidance and disciplinary influence for all its members.

However that may be, the possibilities depend on forces that are beyond the immediate control of the nursing profession as such. The practical ques-

tion for us here is to decide what degree of saturation, such as is now possible, the candidate nurse should attain to.

We cannot go behind recognized certificates of scholastic standing. Admitting all their defects and dubieties, we must allow that efficient conduct of mass education requires them. Remedies for defects must take the form not of discarding these holding-pins so as to let education down in a shapeless sprawl, but of improving and enriching the culture to which they testify, and of fighting relentlessly against the tendency to exaggerate the cash value of a certificate as such. High school leaving standard seems to be the best we can hope for just now, and where high school training is good it may be sufficient. For we must not forget that the next stage, that of vocational specialization, should keep open many possibilities for further culture.

May I add that I disagree with the Survey if I understand rightly that it advocates a special *ad hoc* Nurses' Matriculation? This would be a retrograde step: the adoption of a practice which other professions have discarded. The time for what I call "Saturation" is all too short: its value for the subsequent training is due to its being what it is, a general culture; and as one who has suffered from it I deprecate these all too early predestinations.

Oh! If we draw a circle premature,

Heedless of far gain,

Greedy for quick returns of profit, sure,

Bad is our bargain.

I would rather see a lengthening of the professional training should that prove necessary.

Coming now to specialized professional training, I notice that there is a tendency among nurses to speak rather bitterly and contemptuously of what is called "Apprenticeship." I hope I shall not be thought unsympathetic if I suggest that on this point we should think again. I know well the evils of a system that subordinates the paramount claims of genuine training to the exploitation of cheap, immature labor. I had a little to do with that fight in South Africa in helping to build up the semi-State system of educative apprenticeship that is now in



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operation there. Also I have been through it myself. I served my four years as a very juvenile apprentice — a pupil teacher — in England in the bad old days before the reforms of 1902. I know how much drudgery and how little education there may be, how much premature responsibility, how much lowering of standards of achievement and stifling of the wider powers.

But have we not here a case like that of discipline; a true idea perverted and misapplied by a mistaken and vicious method? Is apprenticeship still wrong when the claims of education are made really paramount, when the pupil is first and foremost a learner and a young worker only *because* he is a learner?

For what is the alternative to apprenticeship? Can it be anything but a school? Faith in schools is apt to be strong when belief in education is weak. Everywhere their severe limitations as instruments of true vocational training are becoming better understood and recourse is had to training-on-the-job, with a specialized kind of school playing a subordinate though necessary part. Do not let us, then, discard the concept of apprenticeship. It is the right notion. Let us rather purge it of its bad economic associations and of the abuse of methods that has so often gone with it. The Survey Report makes excellent recommendations on this point, which I need not repeat. They seem to fall under two heads: (1) The organization of adequate teaching institutions. These can only be hospitals with properly equipped schools attached to them. (2) The provision of properly trained teachers.

There is a new profession here, which will have a great part to play in the future. Whatever we may be able to do here the real task will be theirs. They will be key-people discharging a most vital function, and I trust that the coming organization will be flexible and liberal enough to give them proper scope. In the parallel case of the State schools the teachers have still not achieved their proper share in the making and execution of policy. I trust that hospital boards or other governing authorities will be wise enough to guarantee the "*libertas docendi*" of those upon whom the main task must fall.

But over the whole of this scene of the specialized training I see again the spirit of socialization asking for embodiment. And the claim grows the more insistent the longer I look at the problem.

May I add that, if the schools of nursing of our dreams should really get going, I should look to them to make significant contributions to our knowledge of educational principles and technique. Working in so rich a field, where there are so many points of contact with varied human interests, and guided, as they would be, by highly trained directors, they should yield much that would be of value to us all.

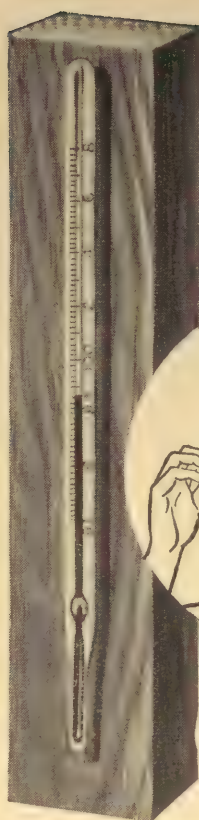
Again, do you observe, that note of *representativeness*!

I come, finally, to what I have called the "Higher Training." The meaning of the term will be clear to you. It refers, of course, to instructors, administrators and directing staff generally. It is here that I smell the smoke of battle, for intensely agitated questions like that of the proper scope and function of universities and that of the rights and status of what may be called the higher professions for women here come upon the scene. So you will forgive me if I tread a little warily. I am prepared to accept right away certain propositions about the training that is called for at this level, the training in a School for Graduate Nurses, if you like. These propositions are:

1. That the training is of unquestioned university level.
2. That it requires urgently the university atmosphere of breadth, leisure and disinterestedness.
3. That those who will take it are beyond all question of university standing.

I can speak from a little experience here, having been brought in touch, academically, with groups of students in a university school for graduate nurses. It seems almost like insulting them to give the assurance that I have been struck again and again by the strength and maturity of mind that many of them displayed, by the keenness of their interest, both professional and intellectual, and by the value of such an experienced leaven in the general student body. But it does not necessarily follow from my acceptance of these propositions that I should agree

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to the further propositions:

1. That the universities should assume sole responsibility for such training.

2. That successful completion of it should be marked by an *ad hoc* degree for nurses as such.

Note that my attitude is non-committal. I do not deny these last two propositions, but neither do I wholly affirm them. There is a fence-sitting attitude for you! Say that if you will. But many things have to be considered.

1. You may look for, and find the subject "logic" in the curricula of universities, but you must not expect to find it always in their policy. They, like other institutions, are the creatures of circumstance and history and accidental pressures, and it does not follow that what they have done once they will do again. With them, as with politicians, the chill of practical necessity may make them insensitive to the fervent heat of logic. Law, Medicine and Theology have their place by ancient practice: Engineering and Architecture and well-established new-comers: Commerce, pushful as ever, is getting well in. Now comes a situation not unlike that of the recognition of denominations in public education — if one sect why not all the rest, and how many might there not be?

2. This necessarily raises acutely the question of the real purpose of a university, that function which it must always put first in considering competing claims. There is debate enough on the question today when universities tend to disappear in a congeries of technological schools. But my own mind is quite clear that the true value of universities will be lost unless we put first the functions — the purely *cultural* function — of saturation, as I have defined it, and the creative function of Research. These, I think, must always have first claim.

3. But this need not mean the complete exclusion of all further professional schools. The problem is largely one of finance. The university's attitude might be different if it did not feel it was robbing its own child Peter to pay a step-child Paul. Is there no possibility of founding schools rather like theological colleges, in close affiliation with universities but with no financial claims upon their general funds? The practice is by no means unknown and some major difficulties might be obviated if it could be followed.

4. As for the degree, if that is demanded, various courses are possible. The wide umbrella of Arts or Science might be capacious enough to cover a very satisfactory degree for nurses. For have I not all along been emphasizing the central representativeness of the nursing profession and its education?

Or the school might give its own qualification with the university's imprimatur. I agree that the issue is largely one of professional status and there may only be one way — that of the nurses' degree as such — to secure the object. But as yet I remain unconvinced.

5. Greatly daring, I venture a last point. What of the future of university degrees in general? "When everybody's somebody, then no one's anybody." Sometimes I long for that day to come, when, with a tremendous slump in the value of university degrees, it may be possible to tempt young people to turn away from pot-hunting to the serious business of their own education. "A man's first social duty," says a wise American, "is his own education." I agree heartily that a great and vital social function like nursing, where the training must be severe, and the work is often arduous and thankless, calls for adequate social recognition. And I agree, too, that such recognition is, to some extent, a factor in efficiency. But in that more rational and better socialized world towards which we hope we are moving standards of valuation may be different. We may learn better to value people for what they are and for the significance of their service rather than for their labels. The salesman and the advertiser will not always rule, and those who have lived with the most satisfaction to themselves and the greatest benefit to mankind rest generally in unvisited tombs.

This may sound like cold comfort, and I may myself be accused of offering the laboring animal spiritual sustenance because I am not prepared to let him have the carrots. Carrots are sweet and pleasant nourishment, but they are not the same thing as a faithful journey. God help us all to know our true reward.

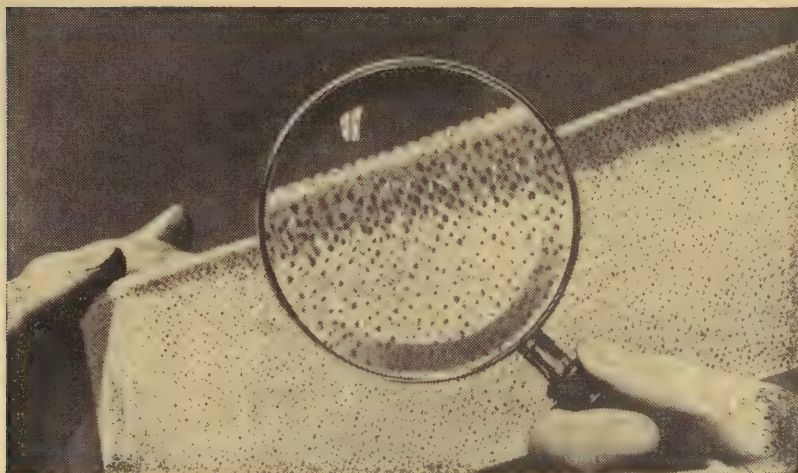
I close on the note with which I began; the thoroughgoing human representativeness of nursing. I have had the privilege of its ministrations as I

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have had the privilege of teaching some of its ministers. I have tried to the best of my ability, to offer some help in the solution of its training problems, and I am left now with a great hope and a great confidence. For your work carries you right into the centre of this human scene, to springs of emotion and action to which many of us cannot penetrate. As I

think of the burden laid upon you, I recall that well-known verse of Blake:

To Mercy, Pity, Peace and Love  
All pray in their distress,  
And to these virtues of delight  
Return their thankfulness.

I can offer no greater tribute to the nursing profession than to say that reflection on its mission and its problems makes me think of that verse.

## In Memoriam

**Jean Balloch**, a graduate of Victoria Public Hospital, Fredericton, N.B., died there in May, 1956. Miss Balloch had served for a time as matron of the hospital in Vernon, B.C. as well as working in New Brunswick.

\* \* \*

**Della Jean (Witts) Coleman**, who graduated from Holy Cross Hospital, Calgary, in 1926, died at Virden, Man., on May 21, 1956, in her 56th year. Following graduation, Mrs. Coleman worked in the hospital at Kenora, Ont., before leaving for Hawaii where she spent several years. She became matron of the Virden hospital in 1953 and interested herself immediately in expanding the institution's work in that thriving community. Her last accomplishment was to convince the Hospital Aid of the need for a fracture table. It has been dedicated as a memorial to her.

\* \* \*

**Elizabeth (Quinn) Corbett**, who graduated in 1916 from St. Joseph's Hospital, Port Arthur, Ont., died at Toronto on May 16, 1956. Mrs. Corbett joined the C.A.M.C. immediately following graduation and served overseas in World War I, marrying at the close. Some years ago when a polio epidemic broke out in Toronto she resumed nursing at the Isolation Hospital. She was on duty there the day before her death. During World War II, Mrs. Corbett worked in Canada for the Free French Movement and was awarded the French Cross of Liberation and the Medal of Recognition.

\* \* \*

**Elizabeth (Domville) Davidson**, who graduated from Royal Victoria Hospital, Montreal, in 1911 died earlier this year in Rothesay, N.B.

**Rosa (Moor) Dawson** died at Toronto on June 15, 1956, following an illness of several months. She had engaged in private nursing in Toronto for many years.

\* \* \*

**Caroline Margaret Hichens-Smith**, who graduated from St. Joseph's Hospital, Victoria, in 1919, died suddenly at her home in Powell River, B.C. in May, 1956. She was 61. Known to her friends as Carrie Smith, she had been on the staff of the Powell River Hospital ever since 1922.

\* \* \*

**Mary Jane (Bannister) Kesselring** died at London, Ont., on May 9, 1956 at the age of 86. For 33 years Mrs. Kesselring had worked at the Owen Sound General and Marine Hospital, retiring some 20 years ago.

\* \* \*

**Olive (Bentley) Mallock**, who graduated from Toronto General Hospital in 1896, died at Toronto on May 16, 1956. Many years ago, Mrs. Mallock was superintendent of nurses at T.G.H.

\* \* \*

**Florence McConnell**, a graduate of old St. Luke's Hospital, Ottawa, died recently following a long illness. She had engaged in private nursing for many years.

\* \* \*

**Florence McDonald**, who graduated from The Montreal General Hospital in 1905, was fatally injured when struck by a taxi in New York City in April 1956. She had engaged in private nursing in Montreal.

\* \* \*

**Gwendolyn Frances (Birt) McGugan**, who graduated in 1922 from the Amasa Wood Memorial Hospital, St. Thomas, Ont., died at Aylmer, Ont. on May 5, 1956.



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**Alice (MacLeod) McIntyre**, a native of Prince Edward Island who had trained at Mt. Sinai Hospital, New York, died at Montague, P.E.I., on May 10, 1956 in her 56th year.

\* \* \*

**Isabella Jane Neilly**, who graduated 41 years ago from Soldiers' Memorial Hospital, Orillia, Ont., died there on May 5, 1956 at the age of 78. Enlisting in the C.A.M.C. early in World War I, Miss Neilly served in England and in the far east. She was honored for her outstanding work during a cholera epidemic in Bombay in 1919. After the war she became assistant superintendent of Memorial Hospital, Listowel, Ont., later doing private nursing in Chicago and Orillia.

\* \* \*

**Charlotte Helen Ross**, O.B.E., a gradu-

ate of the General Hospital, Brockville, Ont., died at Toronto on June 21, 1956. After engaging in private nursing in Montreal for a time, Miss Ross enlisted in the C.A.M.C. and went overseas in 1916. She served in England and France, being mentioned in despatches. After World War I she served as matron at Westminster Hospital, London, Ont., until her transfer to Christie Street Hospital, Toronto, in 1936. In 1948 she was awarded the O.B.E. for her splendid service as chief matron at Christie Street. She had retired at the end of World War II.

\* \* \*

**Clara (Evans) Webster**, who graduated from Toronto General Hospital in 1901, died at Cloverdale, B.C., on April 17, 1956. Mrs. Webster served as matron of the General Hospital, Whitehorse, Yukon, many years ago.

## Leukemia

W. SCHWEISHEIMER, M.D.

**F**EW OTHER DISEASE CONDITIONS call forth the same feeling of utter hopelessness and fear which we tend to associate with leukemia. Our concern in this regard is out of all proportion to the incidence of the disease. The fact that it is a comparatively rare entity is completely overshadowed by the knowledge that the mortality rate of leukemia now exceeds many of the acute communicable diseases such as diphtheria and poliomyelitis. True, the mortality rate is rising but this might be explained partially on the basis of increased public and professional interest and provision of increased, improved and more frequently used diagnostic facilities. As a result, incidence of leukemia is being reported with much greater accuracy. But the average person, lay or professional, remembers mainly that leukemia is of unknown origin, has a tendency to appear in the acute form in childhood or as a chronic condition in adult life, and is inevitably fatal.

The acute form, seen most frequently in youth creates the strongest impression. The course of the disease

tends to be short — ranging from a few weeks to a few months. The means of treatment so often appear frustratingly inadequate. The chronic form, usually associated with adult life, has a much more gradual course being measured, as a general rule, in years. In a recent study one patient was observed who had had the disease in its chronic state for a period of 29 years. Methods of treatment in this instance, although far from perfect, have a more optimistic air.

By definition, leukemia is an "invariably fatal systemic disease of unknown etiology primarily involving the blood forming organs." Pathologically, an enormously increased white cell count is exhibited at some stage. Proportions of 100,000 to 200,000 white cells per cubic millimetre have been attained — many times the normal reading of 6,000-8,000. Sometimes the white cells are not particularly evident in the peripheral blood and for this reason examination of bone marrow is usually a routine measure. The bone marrow may be packed with white cells.

The disease may assume one of three different forms. The *myelogenous* variety tends to produce enlargement

Dr. Schweisheimer resides in Rye, N.Y.

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of the spleen with some glandular enlargement. *Lymphatic leukemia* is characterized by marked glandular enlargement but less apparent spleen involvement. *Monocytic leukemia*, much more rare than either of the other two types, exhibits severe bleeding and edema of the gums. All forms induce anemia fatigue, energy loss and purpura. Logically enough we have come to associate leukemia with malignancy and it is often termed a cancer of the blood. The first clinical manifestation of lymphosarcoma may be the appearance of leukemia. Twenty to 30 per cent of patients suffering from polycythemia vera develop leukemia terminally.

The very high incidence of this condition among radiologists, doctors or nurses, exposed to the effects of x-ray have led to certain conclusions. Either there is failure to observe existing protective techniques properly or present methods are inadequate. In any case, the risk of death from leukemia among radiologists is estimated by one investigator to be 9 or 10 times that of non-radiologists. The possibility of radiation as a causative agent of leukemia is further substantiated by the fact that survivors of a single high exposure to radiation at Hiroshima and Nagasaki had an incidence 13 times as great as those in whom exposure was minimal.

Not all persons exposed to the effects of radiation develop leukemia which suggests that a certain set of "conditions" must be required. This has led to the conclusion that human leukemia is dependent upon a *non-specific hereditary* predisposition to cancer. What other "conditions" would need to be present have not been defined. Age and sex would appear to have some bearing. Lymphatic leukemia has a higher mortality risk during the first two decades of life than during the third and fourth combined. From the fifth decade on, mortality risk tends to increase with longevity. In both white and non-white races, mortality is higher in males.

All black clouds have some silver lining. Although still considerably tarnished, the silver in the black cloud

of leukemia would seem to be in the methods of treatment. Discoveries in the fields of radioactive materials and pharmaceuticals are giving fresh hope. Present methods of treatment might be evaluated as follows:

1. X-ray therapy may tend to aggravate acute leukemia but local or total body radiation or the use of radioactive phosphorus would appear to be the most useful agent in the treatment of myelocytic leukemia.

2. Aminopterin, an amino acid analogue of folic acid, has been found to produce a remission period of several months in children and young adults. Combined with Corticotrophin, even better results are achieved.

3. Urethane (ethyl carbamate) used in combination with x-ray therapy, enhances the effects of radiation and prolongs remission periods.

4. Triethylene melamine has been found to produce complete clinical and hematological remissions in 60 per cent of patients treated. If maintenance doses are given the remission period is prolonged.

5. Nitrogen mustard therapy is of little or no use in treatment of leukemia but is beneficial when used to combat lymphosarcoma with which leukemia may be associated.

6. In addition blood transfusions to control anemia, antibiotics to prevent or overcome infection and maintenance of good morale are all a necessary part of therapy.

While the fact is accepted that with each relapse, treatment becomes progressively more difficult, it is felt that every person with leukemia should be given treatment regardless of how hopeless the outcome may appear. The reasoning behind this is fourfold. Through treatment, painful complications may be alleviated or avoided; children are given an opportunity to lead as active and normal a life of work and play as possible; a period of adjustment is provided for the patient and his family. Finally, there is the ever-present hope that maybe tomorrow someone will find the Achilles heel of this dreaded killer and offer a fresh solution — we cannot deny today's sufferers that possible opportunity.

We have all sufficient strength to endure the misfortunes of others.

— DE LA ROCHEFOUCAULD



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# Quelques Considérations sur l'Anémie et les Etats Anémiques

EUGÉNIE TESSIER

**L**ES MALADES anémiques sont recrutés dans tous les services d'un hôpital général, d'où nécessité pour l'infirmière d'acquérir des connaissances:

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Rôle du laboratoire délimité à des tests spécifiques.

## LA CONNAISSANCE DE LA MALADIE

Nos cours de physiologie nous ont appris, qu'une perte quantitative des hématies et de l'hémoglobine qu'elles renferment, cause un état pathologique se traduisant par une anémie. L'infirmière doit connaître les chiffres normaux d'une formule sanguine. Ces chiffres sont mis en regard du sang analysé, et nous les trouvons imprimés sur les feuilles de rapport des laboratoires. Cet examen de routine est le plus couramment employé pour déceler le degré d'anémie.

Il est intéressant de remonter à l'origine du sang. Le globule rouge adulte de la circulation a eu chez l'embryon son premier développement, même avant que toute circulation ne fut établie. Pendant la moitié de la vie intra-utérine, le mégalo-blaste, précurseur du globule rouge, se divise dans le foie, la rate, pour donner naissance à de nouvelles hématies. Au 5<sup>ième</sup> mois de la vie fœtale, la moëlle assume la fonction hématopoïétique. De la naissance jusqu'à l'âge de 3 ou 4 ans, la moëlle est rouge et active, tandis qu'elle est remplacée par la moëlle jaune vers l'âge de 10 à 14 ans. La moëlle reste active cependant, chez l'adulte, dans les os du crâne, du thorax (côtes, sternum, clavicules), des vertèbres et des os innominés. La produc-

tion des globules rouges et son maintien à niveau normal ne s'opèrent que par une coordination entre la nutrition, l'absorption et la valeur de réserve; les sucs gastriques favorisent l'absorption au niveau de l'intestin ainsi que l'emmagasinement des réserves, par le foie.

Quelles sont, chez l'adulte, les estimations normales de l'hémogramme? Le rapport, plasma/éléments figurés du sang, fourni par l'hématocrite représente normalement chez l'homme 47 vol%; et chez la femme 42 vol%. La formule sanguine établit normalement chez l'homme 5,000,000 à 5,500,000 globules rouges par mm<sup>3</sup>, avec 15.6 grammes d'hémoglobine par 100 cc. de sang (taux correspondant: 100%) et chez la femme 4,500,000 globules à 5,000,000 par mm<sup>3</sup>, avec 13.7 grammes d'hémoglobine par 100cc. de sang (ou un taux de 100%). D'après les chiffres normaux des hématies, de l'hémoglobine et de l'hématocrite, qui peuvent servir de base à des calculs spéciaux, des détails complémentaires s'ajoutent pour préciser le diagnostic, si l'on fait usage des indices suivants:

La valeur globulaire (C.I.)

Le volume globulaire total (Hématocrite)

Le volume globulaire moyen (M.C.V.)

La concentration globulaire moyenne (M.C.H.C.)

L'index de saturation en hémoglobine.

Le diamètre globulaire moyen (d'au moins 500 globules, M.C.D.)

Une diminution plus ou moins marquée de ces standards, démontre un état d'anémie avec cette conséquence que la fonction respiratoire du sang est diminuée. Le globule rouge, par l'hémoglobine qu'il contient, ne peut plus jouer adéquatement son rôle qui est de porter l'oxygène aux tissus et de se charger de l'acide carbonique.

## DIVERSES FORMES D'ANÉMIES

*Les anémies par déficience en fer:*

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Les troubles complexes du métabolisme du fer ont des effets sensibles sur la morphologie du globule rouge, que l'analyste signale dans son rapport hématologique aux item suivants:

*Anisocytose:* La concavité normale du globule rouge peut être accentuée, son diamètre normal de 7.2 à 7.5 microns, réduit. D'autre part, le volume peut être augmenté mais le diamètre fortement réduit, etc.

*Poikilocytose:* L'hématie dont la résistance physique est amoindrie se différencie d'une hématie normale, par la déformation qui en résulte.

*Hématies granuleuses:* Anormalement, la matière basophile s'agglomère et apparaît sous forme de ponctuations plus ou moins ténues, lors de la maturation de quelques hématies. Elles indiquent une légère altération.

*Polychromatophilie:* La substance basophile des stades jeunes est significative. De plus, une diminution de l'hémoglobine est notée sous le nom "d'hypochromie," en se rappelant que la molécule d'hémoglobine — qui est une chromoprotéine — donne la couleur rouge du sang et contient 4 atomes de fer.

A quelles conditions peut être liée une anémie ferriprive? Elle évolue à la suite d'une alimentation pauvre en fer, d'une hémorragie chronique ou massive, ou d'une mauvaise absorption causée par des troubles gastro-intestinaux.

*Les anémies par spoliation:* L'organisme qui subit des pertes de sang par voie interne ou externe, développe un syndrome d'anémie. Pour une étude plus claire, examinons ce qui se passe lors d'une hémorragie massive qui, toujours très grave, peut entraîner la mort par perte considérable du volume sanguin total. Ces hémorragies font suites à des traumatismes que complique une rupture d'organe interne, ou une section d'artère, etc. S'il y a une perte importante de globules rouges et de plasma, dans la période post-hémorragique l'anémie s'établit par dilution. L'équilibre plasmatique, ou volume sanguin total, se corrige assez tôt. Cependant les globules rouges, même avec possibilité active de régénérescence, ne passent que lentement dans la circulation. Exemple: Un gros vaisseau saigne à la suite d'un traumatisme; si l'hémostase s'opère rapidement, l'organisme fait appel à l'activi-

té des centres formateurs pour rétablir la masse sanguine dans la marge de maintien physiologique. Dans d'autres circonstances, il est opportun suivant le degré d'anémie de suppléer à l'action de la moëlle par des transfusions dont les effets sont curatifs. Dans les cas d'ulcères d'estomac qui saignent, la thérapie de choix se porte vers les transfusions pour améliorer, dans un temps relativement court, le volume globulaire. Par cet apport de globules rouges, une intervention est pratiquée avec succès.

Ici, une parenthèse permet de grouper certaines maladies dont les pertes de sang sont imputables à des carences de quelques facteurs de la coagulation. Peuvent entrer en causes: les plaquettes, le fibrinogène, la vitamine K et autres facteurs fort complexes, lesquels sont encore mal connus mais faisant l'objet présentement de laborieuses recherches. Les tests usuels de laboratoire qui aident à dépister ces hémorragies sont:

- Le temps de saignement
- Le temps de coagulation
- Le rétractilité de caillot
- Le signe du lacet (fragilité capillaire)
- Le compte des plaquettes (thrombocytes)
- Le taux de prothrombine (vitamine K)

En poursuivant cette étude nous abordons, ci-contre, des formes d'anémies dont la pathologie est plus sévère.

## ACTIVITÉ MODÉRÉE OU HYPERACTIVITÉ

Deux groupes retiennent l'attention:

a) *Les anémies hémolytiques ou anémies plastiques de causes extrinsèques:* Les globules rouges se forment normalement dans la moëlle, mais ils peuvent être détruits (hémolysés) dans l'organisme par des causes extrinsèques. Parmi lesquelles nous mentionnons:

Certaines formes infectieuses (septicémies à streptocoques hémolytiques)

Certains parasites (l'hématozoaire de la fièvre paludéenne)

Certaines intoxications par agents chimiques (plomb, teintures à l'aniline, sulfamidés, etc.)

Certaines substances sensibilisatrices (incompatibilité de groupes sanguins, facteur Rhésus, etc.)

b) *Les anémies hémolytiques de*

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## causes intrinsèques:

La maladie de Banti (il existe apparemment une destruction trop rapide des globules rouges par la rate)

Les anémies hémolytiques congénitales

Certaines maladies exotiques (l'anémie falciforme, chez les noirs, l'anémie de Cooley, chez les méditerranéens)

De plus l'anémie pernicieuse par manque, dans le suc gastrique, du facteur intrinsèque de maturation des hématies, et les anémies de type pernicieux se rattachent à ce groupe.

Il est néanmoins à remarquer qu'à l'encontre des anémies causées par les hémorragies, ces malades, souffrant d'anémie pernicieuse, supportent assez bien une affection qui signe un chiffre moindre que 1,500,000 globules rouges avec un taux d'hémoglobine variant de 40 à 50%. Par l'étude du myélogramme — éléments de la moëlle osseuse — il est possible de reconnaître, sur frottis, l'état d'activité mégaloblastique. En une telle occurrence, ces patients bénéficieront d'une médication anti-pernicieuse pendant toute la durée de leur vie. Le traitement adéquat, vitamine B<sub>12</sub> ou acide folique ou les combinaisons, s'institue dans les quelques jours qui suivent le diagnostic.

## LES ANÉMIES DE FORME APLASTIQUES

Les anémies de dénominations aplastiques et hypoplastiques orientent le clinicien vers un pronostic sévère.

Le globule rouge dans la circulation passe par les capillaires, se déforme, s'use contre les parois des vaisseaux et finit par mourir. Sa durée de vie est de 14 à 120 jours. On peut donc parler du rajeunissement constant du sang. On désigne par aplasie un manque de rajeunissement. Si la moëlle n'est plus apte à la production équivalente des éléments blastiques, le pronostic est des plus sombres. Un ralentissement de la régénérescence de la lignée rouge, s'observe plus fréquemment qu'une aplasie réelle. Une hypoplasie peut être causée par une toxi-infection, une médication toxique prolongée, des expositions aux rayons x, au radium, des substances radio-actives, etc.

Pour dépister ces états graves entre tous, le laboratoire est appelé à étudier dans le myélogramme, les formes-jeu-

nes de la lignée rouge en suivant les stades de leur développement. Les hématies nucléées, les réticulocytes et la polychromatophilie sont aussi signalés dans le sang périphérique.

Il est à noter que chacune de ces données offre au médecin un tableau hématologique particulier et que des modifications apparaissent aux diverses phases de la maladie. Ces analyses se fixent dans le temps et les variations qui produisent éventuellement, justifient les examens de contrôles demandés en cours de traitement et suivant l'évolution.

## CONCLUSION

En tant que fréquence, si l'on compile les anémies de première identité, et les anémies moyennes qui accompagnent toujours les maladies malignes, nous n'hésitons pas à concéder le fort pourcentage que les statistiques établissent. Il ne faut pas croire, toutefois, que la coloration des téguments soit un critère d'anémie. Si la pâleur du teint peut indiquer un cas de chlorose chez une jeune personne, nous pouvons aussi trouver chez les cardiopéniaux aux téguments décolorés, une formule sanguine normale; et, dans les états de chocs graves, nous décelons plutôt une polyglobulie purement mécanique.

Cet exposé est très peu élaboré en considération des connaissances à portée scientifique qui se reliait à l'universalité du sujet.

De la compréhension des diverses manifestations de la maladie et de l'étude clinique du comportement du patient, découlent quelques raisons mêmes du nursing dans un mode efficace, de serviabilité.

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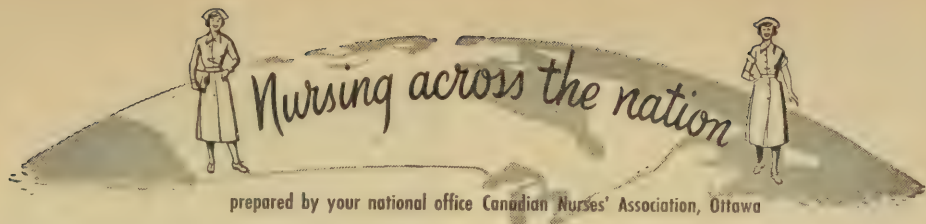
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## **Registration Reaches New High**

Sunny skies, pleasant weather and a total registration of 1390 made the 28th Biennial Meeting a memorable event. Some quick glimpses recall to mind the decidedly international flavor of our gatherings. Three charming Indian nurses, students of McGill School for Graduate Nurses were with us. Added to this were Miss Lucy Germain, vice president, American Nurses' Association; a former secretary of the Jamaican Trained Nurses' Association Miss Thelma Evelyn; Miss Marion West, deputy editor of the *Nursing Times*; a male nurse, Simon Singho, a Colombo Plan student at the University of Toronto.

## **Radio, Press and T.V.**

A scene from "Toward Better Nursing," the dramatic presentation dealing with the Head Nurse Study and presented at the Biennial Meeting was recorded for the CBC program "Roving Reporter." Also interviewed for this program were our newly elected president, Miss Tenna Hunter of Vancouver; Miss Margaret Arnstein, U.S.P.H. Service, one of our guest speakers; Miss Annamma Cherian, soon to return to India; Miss Marion West of England; Mr. Albert Wedgery, Chairman of the Male Nurses' Committee of the R.N.A.O. This 15 minute program broadcast a week after the Convention was an interesting review of a busy week's activities.

In addition, we have so far (July 9) received over 70 press clippings describing the Biennial Meeting. A news release highlighting events to take place at this meeting was sent to all local newspapers with the names of the nurses attending. This initiated local stories in many communities. Winnipeg papers and Canadian Press

"covered" the convention and newspapers across the country picked up the story of Canadian nursing.

## **Our Members Speak**

Twelve hundred evaluation questionnaires were distributed at the Biennial Meeting. Two hundred and twenty-seven were returned. Of these only four reported the meeting as "average," the remainder rated it as excellent or good. A feeling of enthusiasm and friendliness prevailed and the membership felt on the whole that it had learned a great deal.

When asked for suggestions regarding the next meeting the response indicated that an historical pageant reviewing nursing over the past 50 years is favored.

It seems evident that the vast majority feel that guest speakers at a national meeting are preferable to workshops and group discussions which are more successful at the local level.

Many comments suggested that the Mary Agnes Snively Memorial Lecture be held earlier in the week due to the fact many members leave on the last evening of the convention. This special lecture honoring the founder of the CNA has become a tradition. It would seem this is one tradition that is worth adhering to. It is included and is preliminary to the impressive ceremony of the installation of officers and the address of the new president which sets the tone for the coming biennium. Perhaps more explanation of this event and earlier publication of the fact that the meeting closes following this ceremony is indicated. We shall bear this in mind.

More and earlier publicity regarding the program of our meetings is a suggestion to be followed.

We appreciate the time and effort spent filling out these questionnaires





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and will find these suggestions and the many others offered of great help in future planning.

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"Toward Better Nursing" — script of dramatic presenta- tion dealing with Head Nurse Study available upon request.	

### *On to the Future*

"Into the Future Open a Better Way" the theme for the coming biennium chosen by president Trenna Hunter, is indeed most fitting. Taken from an address given by Mary Agnes Snively in 1908 it launches us on to the year 1958 and our Fiftieth Anniversary. Born in Ottawa in 1908 the CNA returns to celebrate its 50th birthday in our capital city.

Plans are already under way — our hostesses the R.N.A.O. and your National Office staff are presently finalizing reservations for our Golden Anniversary. The CNA has grown rapidly during these 50 years. Perhaps it will reach the 50,000 membership mark by '58. We need to think seriously of the part we will play in the future. Miss Hunter expressed this well in her Presidential address at the close of the Convention.

"Into the future open a better way." Almost 50 years later we are still searching for "*the better way.*" Questions are being asked by the patient, by the medical profession, by the public, by ourselves as to whether we really are achieving a "better way" as far as nursing care goes. Our Association is approaching its 50th anniversary but nursing itself is as old as the human race. True we want to look back and to pay sincere tribute to those outstanding and devoted nurses who have made their contributions to nursing in the past, but our real task is to bend our energies to looking for-

ward and to doing our share to preserve what is "true and honorable and of good report" and to develop what is needed in nursing in this changing world. Automation may replace hands in many areas of work but one can never envisage any machine that will replace the ministrations of a truly good nurse. Let us all, as members of the Canadian Nurses' Association, try to keep our minds on the future and see whether we can help to develop truly good nurses and thus "into the future open a better way".

### *The Pilot Study*

The Committee on Nursing Education recommended it, the Executive Committee accepted the recommendation, the General Meeting approved. Now all we have to do is find the ways and means of carrying out the pilot study on evaluation. It is planned that 20 schools of nursing offering diploma programs in basic nursing will be evaluated on a voluntary basis. From this evaluation the CNA will be able to judge whether Canadian schools of nursing are ready for a full program of evaluation and eventual accreditation. The selection of schools of nursing will be made from those that signify to their provincial associations their willingness to participate in the study. Subject to the approval of the Committee on Finance, suitable personnel will be sought and prepared, to carry out the project when the necessary financial backing has been procured.

### *N.B.A.R.N. Celebrates 40 Years*

This is a year of note for New Brunswick nurses. Forty years ago legislation for nursing was passed.

In October the N.B.A.R.N. will celebrate this anniversary with a special program at its annual meeting. Particular emphasis will be placed on nursing education because of the study that has been undertaken during the past year by Miss E. Kathleen Russell, one of Canada's leading nursing educationalists. May we add our congratulations to the many that will be received and our good wishes for the future.

---

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# Le Nursing à travers le pays

## *L'inscription atteint un nouveau sommet*

Un ciel ensoleillé, un temps agréable et une inscription de 1390 membres ont fait du 28e Congrès biennal un événement mémorable. En regardant se dérouler les assemblées, leur caractère international se révèle à notre esprit; assistaient au congrès trois charmantes infirmières indiennes, étudiantes à l'Ecole supérieure des Infirmières de l'Université McGill. Mlle Lucy Germain, vice-présidente de l'"American Nurses' Association"; l'ancienne secrétaire de "The Jamaican Trained Nurses' Association", Mlle T. Evelyn; Mlle M. West, rédactrice adjointe du journal *Nursing Times*, et un homme ayant le titre d'infirmier (male nurse) dans son pays, M. Simon Singho, étudiant à l'Université de Toronto sous les auspices du plan de Colombo.

## *La presse, radio et télévision*

Une scène de "Vers un meilleur nursing," une dramatisation se rapportant à l'étude des fonctions et des tâches de l'infirmière-chef à l'hôpital, présentée lors du congrès, fut enregistrée pour le programme "Roving Reporter" de la C.B.C. Les personnes suivantes furent interviewées. La nouvelle présidente élue, Mlle Trenna Hunter de Vancouver; Mlle M. Arnstein du Service de l'Hygiène Publique des Etats-Unis, l'une de nos conférencières; Mlle A. Cherian, qui doit prochainement retourner aux Indes; Mlle West, d'Angleterre; et M. Albert Wedgery, président du Comité des "male nurses" de l'Association des Infirmiers de l'Ontario. Ce programme d'une durée de 15 minutes, présenté huit jours après le congrès, fut une revue intéressante des événements d'une semaine très chargée.

Nous avons reçu à date plus de 70 découpages de journaux, se rapportant au congrès. Une initiative du congrès fut d'envoyer aux journaux des diverses localités le nom des infirmières de la région assistant au congrès. Ce fait fut souvent le point de départ d'un article dans le journal. Les journaux de Winnipeg et la Presse Canadienne donnèrent le compte-rendu du congrès et les journaux du pays furent ainsi mis au courant de l'histoire du nursing au Canada.

## *La parole est aux membres*

1200 questionnaires, portant sur la valeur

du congrès, furent distribués. 227 furent retournés. Quatre seulement ont évalué les assemblées comme "ordinaire"; les autres les évaluèrent "excellente ou bien." Les membres sont tous unanimes sur l'esprit amical régnant parmi les congressistes et sur le fait que le congrès leur avait appris bien des choses. A la question demandant de faire des suggestions pour le prochain congrès biennal, il semble qu'un pageant historique sur les 50 dernières années soit en faveur.

Plusieurs commentaires furent faits sur la conférence en mémoire de Agnes Snively. L'on suggéra qu'elle ait lieu plus tôt dans la semaine, car plusieurs membres sont obligés de partir le dernier soir du congrès. Cette conférence en l'honneur de la fondatrice de l'Association des Infirmières Canadiennes est devenue une tradition et une tradition qu'il faut conserver. Au début se déroule l'impressionnante cérémonie de l'installation des dignitaires et la nouvelle présidente, dans son adresse, indique la marche à suivre durant les deux prochaines années.

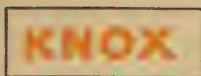
Il se peut que plus d'explications à propos de cet événement clôturant le congrès soient indiquées. Nous y repenserons. Une plus grande publicité au sujet du programme, faite plus tôt, est une autre suggestion que nous mettrons en pratique.

Ces suggestions et d'autres qui nous furent faites nous aideront beaucoup et nous remercions les personnes qui ont pris le temps et fait l'effort de répondre à ce questionnaire.

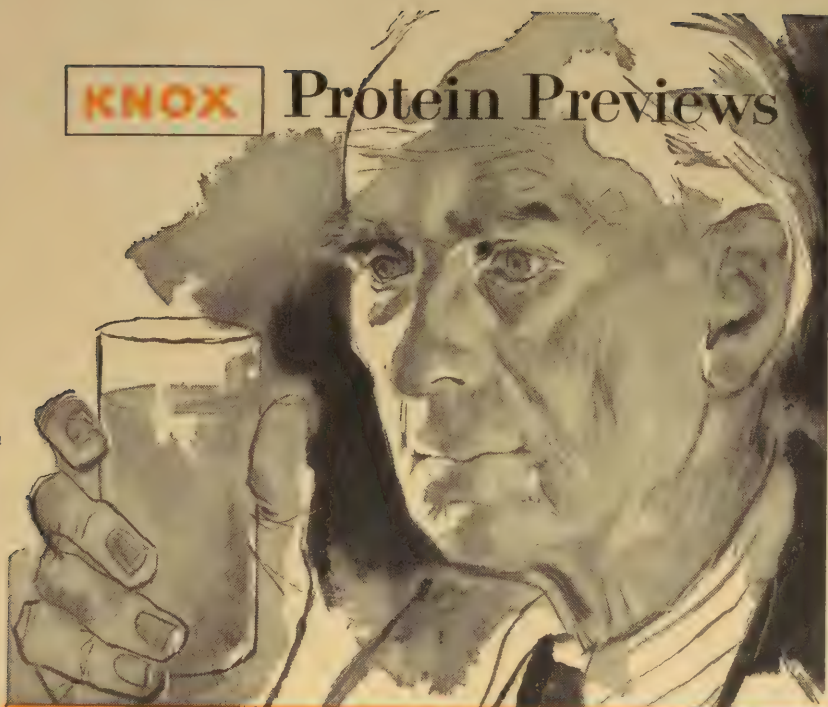
## *Pour l'avenir*

"Ouvrir un meilleur chemin vers l'avenir," voilà le thème choisi par la présidente, Mlle Trenna Hunter, pour les deux prochaines années, et il convient bien. Il est extrait d'une adresse que prononçait Mary Agnes Snively en 1908, thème qui nous a conduit jusqu'à 1958, année marquant le cinquantenaire de l'A.I.C. Née à Ottawa en 1908, l'A.I.C. célébrera dans sa ville natale son 50e anniversaire.

Des projets sont déjà élaborés; notre hôte sera l'Association des Infirmières de la province d'Ontario. Au secrétariat national l'on termine les démarches pour la réservation des salles pour notre Jubilé d'or. L'Association des Infirmières Canadiennes a augmenté depuis 50 ans; nous serons peut-être 50,000 en 1958. Il faut penser sérieusement au rôle que nous jouerons dans l'avenir.



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Mlle Hunter a bien parlé dans ce sens le discours qu'elle prononçait lors de la dernière séance du congrès.

"Ouvrir un meilleur chemin vers l'avenir?" Après 50 ans, nous cherchons encore "un meilleur chemin." Les malades, les médecins, le public et nous-mêmes, nous nous demandons si vraiment nous avons trouvé un "meilleur chemin" dans le soin donné aux malades. Notre Association célébrera son 50e anniversaire, mais le nursing est aussi vieux que le monde. Nous voulons jeter un regard sur le passé et rendre hommage aux infirmières illustres et dévouées qui ont contribué au nursing de leur temps. Notre véritable tâche est de tendre toute notre énergie vers l'avenir et faire notre part pour conserver "ce qui est vrai, honorable, de nature à augmenter notre réputation" et de développer ce qui est nécessaire au nursing dans un monde en pleine évolution. L'automatisation peut remplacer les mains dans bien des domaines du travail mais personne ne peut s'imaginer une machine remplaçant les soins dévoués d'une bonne infirmière. Tous, comme membres de l'Association des Infirmières Canadiennes, essayons de penser à l'avenir et voyons si nous ne pouvons aider à former de véritables bonnes infirmières. et ainsi "ouvrir un meilleur chemin vers l'avenir."

#### *Traduction simultanée*

Un autre événement du congrès fut la traduction simultanée; au fur et à mesure que se déroulaient les débats, les membres de langue française, les écouteurs aux oreilles, les entendaient se répéter dans leur propre langue. A souligner aussi, la belle présentation bilingue du programme et des fascicules publiés par l'A.I.C.

#### *Dignitaires de l'A.I.C. 1956-1958*

Présidente — Mlle Trenna Hunter, directrice en Hygiène Publique du "Metropolitan Health Committee" de Vancouver, B.C.

1ère Vice-Présidente — Mlle Alice Girard,

Directrice du Service du Nursing, Hôpital St-Luc, Montréal.

2e Vice-Présidente — Mlle Helen Carpenter, Professeur adjointe, Ecole d'infirmières universitaire de Toronto, Ont.

3e Vice-Présidente — Mlle Electa MacLennan, Directrice du Nursing, Université de Dalhousie, Halifax, N.E.

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"Vers un meilleur nursing" — texte de la dramatisation de l'Etude sur les fonctions et les tâches de l'infirmière-chef à l'hôpital — sur demande.

#### *Projet d'accréditation*

Le comité de l'Education en Nursing a recommandé l'accréditation d'un certain nombre d'écoles d'infirmières à titre d'essai, en vue de fournir un bon échantillon de la valeur de nos écoles d'infirmières au Canada; le comité Exécutif a accepté cette recommandation et l'assemblée générale l'a approuvée. Maintenant, il nous reste à trouver les moyens de faire cette étude. Le projet consiste à évaluer 20 écoles d'infirmières offrant différents programmes du cours de base. Les écoles seront libres d'accepter ou de refuser l'évaluation. Après cette étude, l'A.I.C. pourra juger si les écoles d'infirmières du Canada sont prêtes à participer à un programme général d'évaluation et, éventuellement, d'accréditation. Le choix des écoles sera fait par les associations provinciales parmi celles qui auront témoigné leur désir de participer à l'étude. Avec l'approbation du comité des Finances, un personnel adéquat sera choisi et préparé pour conduire à bonne fin ce projet lorsque les argentés nécessaires auront été trouvés.

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\* \* \*

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- (4) Regional Superintendent, 522 Dominion Public Building, Winnipeg 1, Manitoba.
- (5) Zone Supervisor of Nursing, Box 292, North Bay, Ontario.
- (6) Zone Supervisor of Nursing, P.O. Box 3427, St. Roch Branch, Quebec, Que.
- (7) Moose Factory Indian Hospital, Moose Factory, Ontario.

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Dans un département d'obstétrique, les accouchées succèdent aux accouchées, et le mal de la dernière ressemble étrangement au mal de la première. Nous ne devons cependant pas oublier que pour chacune qui revient de la salle de délivrance, c'est une

aventure personnelle, merveilleuse sans aucun doute, mais combien pénible et douloureuse dans la majorité des cas. Chacune peut seule savoir l'amplitude des émotions qu'elle a connues. Elle en est encore toute vibrante lorsque nous la recevons au département. Sans être en mesure d'exprimer les sentiments qu'elle ressent, sans savoir expliquer la situation physique et morale dans laquelle elle se trouve, la nouvelle accouchée n'en a pas moins le besoin d'être comprise.

Qui, mieux que l'infirmière, dont la première qualité est d'être attentive aux besoins de ses patients, peut comprendre cet état d'esprit de la nouvelle maman que l'on a confiée à ses soins? Cette compréhension, cette sympathie de l'infirmière se manifeste d'abord dans l'accueil chaleureux, affectueux même qu'elle fera à la nouvelle venue. Comme doit sembler pénible à la patiente

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un accueil dépourvu de chaleur, pouvant lui donner l'impression qu'elle est de trop, qu'elle arrive mal. Elle a tant besoin d'oublier le côté pénible pour être toute à la joie de posséder enfin son enfant.

Son court séjour à l'hôpital représente souvent pour la mère de famille, le seul temps pendant lequel elle se reposera vraiment, abandonnant à d'autres mains le soin de son bien-être physique et moral. C'est donc de l'infirmière qu'elle attend les traitements et les mille petits soins physiques, installations confortables, repas bien servis, ordre, propreté autour d'elle. C'est également à l'infirmière qu'elle confiera souvent ses inquiétudes, ses problèmes, ses soucis de toutes sortes. Elle en fera sa confidente, comptant sur sa discrétion.

L'infirmière consciente de son rôle répondra à la patiente dans la mesure où elle saura être vraiment attentive et sincèrement humaine.

Etre humaine pour nous, dans les cas qui nous occupent actuellement, c'est s'assurer

que la mari est prévenu de l'arrivée de sa femme à la chambre qu'elle occupera, c'est recevoir la famille avec gentillesse.

Etre humaine pour nous, c'est s'intéresser à l'enfant, c'est vouloir le connaître c'est accepter sans mauvaise humeur la visite quotidienne qu'il fait à sa mère, même si cela dérange notre plan de travail. Laissons à la maman toute la liberté de caresser son bébé, de lui parler, de le contempler, effaçons-nous discrètement. Respectons chez nos patientes ce droit d'aimer qu'elles ont acquis si chèrement.

Etre humaine, c'est encore admettre que certaines patientes mettront plus de temps à se rétablir et réclameront davantage nos soins.

Etre humaine, enfin, pour l'infirmière, c'est aimer sincèrement ces êtres que la maternité élève au-dessus d'elle-même.

CARMEN CALVÉ, étudiante infirmière

Extrait de *L'Amie*, journal des étudiantes infirmières de l'Hôpital Général de la Miséricorde.

Iran has banned cultivation of opium poppies and non-medical use of opium. At tremendous economic sacrifice, Iran ploughed

under 30,000 acres of poppies, closed hundreds of opium resorts and distributed millions of anti-opium pills..





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## Book Reviews

**Selected Writings of Florence Nightingale**, by Lucy Ridgely Seymer, M.A. (Oxon.) S.R.N. 397 pages. The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2, Ont. 1954. Price \$5.00.

*Reviewed by Miss Agnes J. MacLeod, Director of Nursing Services, Treatment Division, Dept. of Veterans Affairs, Ottawa, Ont.*

Like her other publications this latest book will have great historical value for all students of nursing. Much of its content is available to the modern reader for the first time and we owe a debt of gratitude to the author for this compilation in one volume of Florence Nightingale's most valuable writings.

It contains nine works in all, arranged chronologically, which were written after Florence Nightingale returned from the Crimea during the years 1858-94. Introductory statements have been inserted before each one, in order to recall the circumstances under which each one was written and to indicate its particular significance. Other than this the actual text has not been "edited" as it was felt "that Florence Nightingale should be allowed to speak for herself and her writings be judged on their intrinsic merit."

The main theme in all Miss Nightingale's work was how the conditions of the sick and the poor, at home and abroad, could be improved. The training of nurses and their introduction into all organizations attempting to care for or supervise the health of the sick poor in the city or rural community was her aim. One cannot help but wonder how much better nurses and the profession would now be, if more of her followers had stood out more firmly for the basic principles which she enunciated for school of nursing organization and for medical-nursing relationships.

To the more senior professional nurse, be she director of nursing, teacher, supervisor or head nurse, this book is fascinating reading. Any nurse who has served with the Active Forces should not fail to compare the first article in this book with her own experiences in order to judge how far we have progressed in the past hundred years. To the young nurse and student, much that Florence Nightingale lays down as regulation will seem unduly severe. Yet no one will fail to see the honest searching, the great humanity, as well as the tremendous

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drive behind all her endeavor to improve the world in which she lived.

**Textbook of Pharmacology and Therapeutics** by Harold N. Wright, M.S., Ph.D. and Mildred Montag, Ed.D., R.N. 557 pages. W. B. Saunders and Company, Philadelphia and London. 6th Ed. 1955. Price \$4.75.

*Reviewed by Mrs. Helen Rawlings, Caughnawagha, P.Q.*

The book is divided into units each dealing with drugs and their action on specific areas. The authors' purpose is to bring the study of new drugs up-to-date and the book is well interspersed with diagrams and charts for easy reference.

The first unit deals with orientation to pharmacology and therapeutics, how drugs are administered, their pharmacologic basis, their action and classification. Each drug is dealt with individually as to the dosage, method of administration, duration of use and effects, both useful and toxic. Drugs are classified according to their action on the different systems of the body. Vitamins, enzymes, hormones and antihormones are fully discussed as to their action and source as well as their therapeutic uses. Poisons

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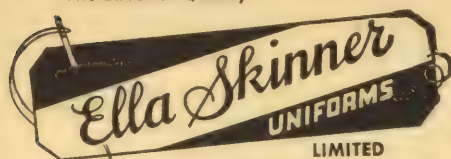
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### For Nurses in Industry For Schools of Nursing **OCCUPATIONAL HEALTH NURSING**

By Mary Louise Brown, in association with J. Wister Meigs, both of Yale University School of Medicine. Here is a top-ranking new book for nurses in industry and for teachers and students in schools of nursing. Miss Brown is an unusually well-qualified author. Before her five years of teaching at Yale, she was herself an industrial nurse for nearly ten years. Dr. Meigs' assistance is important in defining doctor-nurse collaboration in an industrial set-up. \$5.50

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are classified under two types: Domestic poisons and treatment as found mostly in homes; industrial poisons which take in those caused through inhalation of gases and vapors.

Other units deal with the anti-infective drugs, drugs acting on skin and mucous membranes, drugs acting on the nervous system, cardiovascular system and blood, and drugs acting chiefly on the smooth muscles of the gastrointestinal, urinary, respiratory, and reproductive tracts. One unit is devoted to the therapy of neoplastic diseases.

A chapter discusses legislation in regard to the use of drugs in the United States. Another chapter outlines pharmacology from 5000 B.C. up to the present time. Canadian drug legislation, which was written by Charles Nash, B.Sc., Ph.D., an associate professor of Pharmacology of the University of Alberta, is discussed under historical development, Food and Drug Act, the Opium and Narcotic Act, the Proprietary or Patent Medicine Act and the Pest Control Products Act.

The book serves the purpose of an interesting informative text. Due to its good index it is also valuable as a reference book.

### Introduction to Psychiatric Occupational

**Therapy**, by Gail S. Fidler, O.T.R. and Jay W. Fidler, M.D. 200 pages. The Macmillan Co. of Canada, Ltd., 70 Bond St., Toronto 2, Ont. 1954. Price \$4.00.

*Reviewed by Miss Judith Kingsford, Instructor, Ontario Hosp., St. Thomas, Ont.*

The author of this book has defined his chief objective clearly which is to integrate the occupational therapist as a member of the psychiatric team by using her trained knowledge of non-verbal activities. Her work then has a "treatment centred" rather than a "product centred" objective.

Concise, easily assimilated language has been used to describe the occupational therapist's training. Where psychiatric terminology is used, a full explanation is included for the lay reader. The book's content has been divided into nine sections which include a definition of occupational therapy, the functions of the therapist, case histories and progress notes. The general principles of occupational therapy are well outlined stressing the dynamics, the emotions and personalities of the individuals concerned — the patient and therapist. Ideas expressed are not always too practical for the large institution, e.g. "Prescription of Activity" written by the attending doctor. This has



advantages which would benefit a newly admitted or chronic regressed patient but follow-up would appear difficult with many patients.

The use of progress notes is suggested and the advantages of doing so either with patients who are mentally ill or those with physical conditions can be seen. The author stresses that suiting the activity to the patient's mood responses is the goal of the therapist. Thus the patient can give vent to his emotions in an environment where controls are enforced only as necessary.

In summary, this is a book that should appeal to anyone in the field of learning. It is written clearly and case and interest histories are used to illustrate as necessary. The importance of coordinating and paralleling occupational therapy with other treatment in psychiatry is emphasized rather than looking upon it as diversional activity.

**Understanding People in Distress**, by Barney Katz and Louis Thorpe. 351 pages. The Ronald Press Company, 15 East 26th Street, New York 10, N.Y. 1955. Price \$4.00.

*Reviewed by Mrs. E. L. Brooks, Psychiatric Division Shaughnessy Hospital, Vancouver, B.C.*

Two renowned psychologists have made a worthy attempt to bring to the attention of the public the causes, symptoms and treatment available for those in mental distress. Their aim of showing that this affliction need no longer be regarded with an air of mystery has been ably fulfilled. Throughout the book they deal with the concept of stress and use this as the basis of all mental illness.

The authors give simple explanations and illustrative case reports of varied emotional and mental disorders ranging from mild frustrations to a complete mental breakdown. They discuss sociological factors in which cultural aspects are brought in as additional causes of distress. A clearer perception of mental illness is afforded with a hopeful outlook for the individual afflicted. The understanding acceptance by those surrounding him will be aroused.

Considerable space is devoted to the neuroses. They are the results of inadequate satisfaction of basic needs. It is impressed on the reader that somatic symptoms are real, the pain and suffering intense. Other chapters deal with delinquency and crime, drug addiction, alcoholism and unusual sexual behavior. It is felt that these problems arise from emotional conflicts and insecurity

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in childhood and adolescence. Various types of psychoses, their causes and symptoms, together with modern methods of treatment and prevention are also discussed.

This book is intended for the student of human relations. In very simple language it deals with the symptoms and possible results of mental illness rather than the dynamics of psychiatry. As an introductory text it is invaluable.

### **The Practical Nurse and Her Patient,**

by Fern A. Goulding, R.N., M.S. and Hilda M. Torrop, R.N., B.S. 319 pages. J. B. Lippincott Company, 4925 Western Ave., Montreal 6. 1955. Price \$4.25.

*Reviewed by Miss E. Groenewald, Director, Montreal Central School for Nursing Assistants, Queen Mary Veterans Hospital, Montreal.*

Here is a valuable fund of information, not only for the trained non-professional member of the nursing team but for anyone caring for infants, children, the aged or the sick in the hospital or the home.

The 28 chapters of the book discuss important points underlying basic nursing care and skills in the field of the practical nurse and offer helpful suggestions to assure total care of the patient. References, which give the actual steps of the nursing procedures discussed are listed at the conclusion of each chapter. Especially fascinating is the chapter on "Diversions for the Sick" which contains a wide range of suggested mental and physical activities for convalescent patients of all ages and with varied tastes.

The alphabetical arrangement of data as given in the sections on methods of stain removal and administration of first aid to the injured; the tables for food selection and the 45 appropriate illustrations are some of the factors which make the book a useful, quick and handy reference.

With a relaxed simplicity and clarity of style and by using a positive practical approach throughout, the authors have prepared a text that is authoritative and inspiring.

\* \* \*

A new film "The Patient is a Person" has just been made available for use by medical personnel and organizations. The film explores the attitudes of fear which many patients exhibit on entering the hospital. It suggests techniques of non-medical care which may help to allay these fears and contribute to the patient's rapid recovery. The film may be obtained from the American Medical Association or the American Hospital Association.



## Scientists Probe Foot Health

The foot comfort and health of future generations is being assured by the work of a group of scientists at a block of modern laboratories in a small English country town. Described in a U.S. trade journal not long ago as the "World's Top Shoe Research Centre," it is the British Boot, Shoe and Allied Trades Research Association (better known in the trade as Satra) at Kettering in Northamptonshire.

While appearance, protection, weather resistance are all important, comfort in the widest meaning of the term is put first. And comfort is not just a matter of finding a shoe that does not pinch or restrict the foot; physiological comfort has to be considered so that the feet are neither too hot nor too cold and are not made subject to excessive perspiration. They must also be orthopedically comfortable — that is to say, they must not harm the wearer's posture.

Thus, research undertaken by Satra delves into all aspects of the shaping of the shoe and the materials from which it is made. Their findings apply equally well to overseas countries inhabited by people of European descent. (A survey of the foot characteristics of the British and U.S. armies revealed no fundamental differences.)

Prescribing the kind of shoes that people should wear means, first of all, finding out just what the human foot has to put up with throughout its life. To do this, thousands of feet of all kinds and sizes were accurately measured and from this a number of lasts was produced on which shoes can be made that will fit practically every type of wearer. This precision grading has considerably simplified shoe sizing.

A particularly important part of the Association's work has been in the research carried out into children's shoes, and their findings have done much to awaken interest throughout Britain in the problems involved. Unfortunately a child's bones are so soft that the young wearer cannot tell whether a shoe is too tight or not. The results appear later in life in the form of bunions and other deformities. Now a series of lasts for children of different ages is helping to eradicate these troubles.

In order to test the qualities of shoes, Satra adopts the simple but effective expedient of trying them out on local schoolboys, postmen, bus conductors and industrial workers. In addition, a number of ingenious



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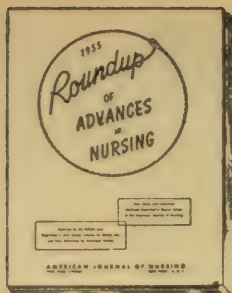
Veganin helps to bring swift welcome relief at specially difficult times, or at any time pain strikes . . . helps to calm jittery nerves without producing a feeling of drowsiness or upsetting the stomach.

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machines in the laboratories have been designed to simulate various kinds of treatment. There is, for example, a machine that drops a heavy weight on the reinforced toecap of a safety boot while a device measures the moment of maximum depression. There is a machine that simulates walking, and another that flexes soling materials. There is also an impact tester for steel shanks as well as a shoe bumping machine which applies repeated hammer blows to the sole.

Humidity and refrigeration conditions are both available and the ability of particular material to absorb water is carefully checked.

The knowledge that is being built up day by day in Kettering is invaluable, particularly when worn shoes are returned because they have failed in some way to satisfy their owners.

There was one query from the Trinidad oilfields where workers' boots were wearing out much too quickly because of oil and chemical splashes. Another came from the gold fields of South Africa. In the latter case Satra tackled the problem of wear by analyzing the soil on miners' boots.

Probably the most famous boots ever designed by the Association were those used

by the triumphant 1953 Everest Expedition. After the conquest of the world's highest mountain, the leader, Sir John Hunt, wrote to Satra — "the boots were a great success and were worn constantly by all the party from 20,000 feet upwards."

— UNITED KINGDOM INFORMATION OFFICE

\* \* \*

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It must appeal to you.

It must suit you age.

It must fit in with the time you can give it.

It must be adapted to your ability.

It must fit your pocketbook.

— Canadian Welfare

\* \* \*

We are here not to get all we can out of life ourselves, but to try to make the lives of others happier.

— SIR WILLIAM OSLER

\* \* \*

One good way to save face is to keep the lower half of it shut.

\* \* \*

National Immunization Week, which will be observed starting September 23, is an annual reminder. This event is part of the continuous campaign carried on by official health departments against those communicable diseases which can be controlled by immunization. Smallpox, diphtheria, whooping cough, tetanus and poliomyelitis form the list of diseases in question. Canada possesses a good record in the control of these conditions. Smallpox is practically nonexistent and the incidence of diphtheria is greatly diminished. Neglect in taking advantage of immunization measures could easily mean that diphtheria could again become prevalent. Whooping cough is still a serious disease with 13,682 cases reported in 1955.

During National Immunization Week the Health League of Canada, in cooperation with departments of health throughout Canada, will try to inform every Canadian citizen of the reason why immunization is so necessary. It is hoped that thousands of parents will see to it that their children are protected now and in the future.

\* \* \*

If you make a right turn from a left lane you are probably just careless, and not really what the driver behind called you.

\* \* \*

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## THE ASSOCIATION OF NURSES OF THE PROVINCE OF QUEBEC

The 1956 Fall Examinations for Provincial Registration will cover two groups of candidates, and will be held as follows:

### Examinations for Registration — Part II:

Graduates desiring to qualify for a license to practise will write on *November 19th, 20th and 21st, 1956*. Candidates will not be permitted to write these examinations until they have actually completed their training and hold the diploma of their school.

*Applications must be received by October 15, 1956.*

### Examinations for Registration — Part I:

Students who will have completed their first year will enter the Examinations for Registration, Part I, which will be held on *October 22nd, 23rd, 24th and 25th, 1956*.

(Time to be announced in each school.)

*Applications must be received by September 18th, 1956.*

For application forms and all information relating to the examinations, apply to the headquarters of the Association.

**A. WINONAH LINDSAY, R.N.,**

**Secretary-Registrar**

**Suite 506—1538 Sherbrooke Street, West  
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# News Notes

## ALBERTA

### DISTRICT 3

#### BANFF

The Bursary Committee has decided to postpone the time of its award until September when final school results have been obtained. The student receiving the bursary is to be given a suitable book as a gift from the Chapter.

#### CALGARY

The Chapter members agreed to notify two hospitals that bursaries are available for students since the Bursary Account has sufficient funds for this purpose. A supper meeting is planned for October in Holy Cross Hospital auditorium.

#### Holy Cross Hospital

The classes of '50 and February, '53 held reunions during the earlier part of this year. Mrs. (Michaluk) Saluk recently joined the hospital staff. M. Nickols is joining the staff of the General Hospital while D. Humphries has returned to her home school. Lieut. A. C. (Rimmer) Stillinger has been transferred from California to a naval hospital in Italy. Sr. Nadeau has returned to the staff as head nurse on St. Marie's ward. S. McBeath is working at Galt Hospital, Lethbridge. G. Munro has enrolled for the postgraduate course in obstetrics at Margaret Hague Hospital, Jersey City, N. J. F. Tenant recently assumed the duties of public health nurse and Mrs. (Hutton) Jaques is now supervisor on St. Anne's ward. The 50th anniversary of the school of nursing will be observed late in 1957. A reunion of alumnae members is being planned as part of the celebration with Mrs. (Wannop) Brown in charge of arrangements for this particular event.

#### OLDS

Regular meetings are to be resumed in September under the leadership of Mrs. B. Galvon with M. Kirker serving as secretary-treasurer. It is hoped that films and lectures on modern nursing techniques can be included in the program as well as refresher subjects.

#### VULCAN

Home nursing classes have been completed and equipment kept on hand for possible future use. Members practised various methods of artificial respiration under the direction of Lundy Findlay, their June guest speaker.



## LETHBRIDGE

A new rehabilitation centre is to be opened shortly and members have volunteered their assistance for that day. Miss Prowse, representing the student nurses, was guest speaker at the June meeting and reported on the student's convention in Banff. Miss Griffin was the official delegate to the Biennial Convention.

## BRITISH COLUMBIA

## CHILLIWACK

The Enid Chadsey Bursary was presented by I. Brown, chapter president, to A. Stark. Miss Stark plans to start her professional training at the Vancouver General Hospital this fall. A vote of thanks was extended, at a recent meeting, to Mrs. H. Bersea and Mrs. E. Penner for their untiring efforts in arranging for the successful Novelty Tea held early in the year. A district meeting was held in July with members of this chapter acting as hostesses.

## NANAIMO

Two bursaries have been awarded by this chapter to graduates of the local high school who have chosen to enter nursing. A Bursary Tea is to be held in October to raise funds for similar presentations. The June chapter meeting took the form of a dinner meeting.

## PENTICTON

J. Appleton was hostess at a buffet supper when chapter members met in June. Mrs. A. Mason was in the chair for the business session. The semi-annual meeting of the Kamloops-Okanagan district will be held on October 19.

Mrs. V. Crittenden attended the Biennial Convention as official chapter delegate. A successful home cooking sale netted \$65. Dr. Kathleen Ellis presented the Kathleen Ellis Bursary to L. Christian who plans to enter the Vancouver General school of nursing next February. This bursary is awarded by the chapter to an outstanding high school graduate choosing nursing as a career.

## MANITOBA

## ST. BONIFACE

*St. Boniface Hospital*

Graduation exercises were held late in May in the playhouse Theatre. The award winners included: P. Fee, alumnae scholarship; J. Bollen, general proficiency; A. Forest, bedside nursing; E. Green, theory; L. Elmhurst, executive ability; G. Besel, school citizenship.

Graduates visiting their home school after a prolonged absence will find many interesting physical features in the new wing. The division includes a modern postanesthe-



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**BASE SALARY** — Begins at \$270 per month, without experience. Experience qualifies for higher starting salary.

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DEPARTMENT NS,  
ROOSEVELT HOSPITAL  
59th Street West,  
New York City**

sia department, surgical recovery room and emergency department. A cobalt bomb is housed in the enlarged radiation therapy unit which is administered by the Manitoba Cancer Institute. The old division of the hospital is to undergo complete renovation and when accomplished will bring the hospital capacity to 750 beds.

## NEW BRUNSWICK

### FREDERICTON

Forty members motored to Nashwaaksis and enjoyed a turkey dinner served by the Women's Auxiliary of St. John's church as part of their June meeting. A short business session was conducted by Mrs. H. H. MacLeod, the new president. I. Richards, who spent some time in England on a Beaverbrook scholarship, was an entertaining guest speaker.

### MONCTON

Miss Mildred Walker, nursing consultant in Occupational Nursing, Dept. of Health and Welfare was a guest speaker at one chapter meeting. She extended a cordial invitation to members to attend the institute on "Communications — a Factor in Good Public Relations." This institute proved to be most successful. A symposium, "Nursing Aspects in Rehabilitation and Care of the Chronically Ill" was presented by D. Steeves, C. Donovan and R. MacKenzie.

E. Larracey has returned to the Hotel Dieu following completion of her course in teaching and supervision at Dalhousie University. M. McCallum, Moncton Hospital, successfully completed a course in pediatric nursing at University of Toronto. M. Hollenbach and K. Richardson attended the institute conducted by Dr. Bixler at Dalhousie University earlier this year. Those who attended the Biennial Convention included H. Hayes, L. Good, R. Hartt, M. Matchett, K. Richardson, Mrs. D. Van Buskirk, Mrs. I. Bourgois, A. Bourque. J. Howland represented the student nurses of Moncton Hospital. Miss M. Archibald, executive secretary-treasurer, was the guest speaker at the last meeting for the spring and summer months. She gave an interesting description of the work of the provincial office staff.

### NEWCASTLE

Miss Muriel Archibald, secretary-registrar, N.B.A.R.N., addressed members attending the annual dinner meeting of Miramichi Chapter. The 1956 graduates of Miramichi and Hotel Dieu hospitals were honored guests. Miss Archibald stressed the importance of provincial registration noting that the efforts of a group are always more productive than those of an individual in achieving the aims of nursing. She gave detailed information in relation to registration in the province, explained the relationship to national and international organizations and discussed the steps necessary in transferring from one province to another.

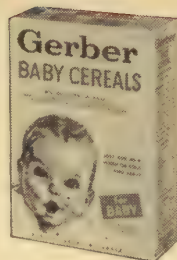


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NIAGARA FALLS, CANADA



Miss E. MacDonald thanked the speaker.

#### **ONTARIO**

##### **DISTRICT 4**

##### **NIAGARA FALLS**

The 1956 graduates of the local General Hospital and St. Catherine's General Hospital were guests of honor at the annual picnic meeting of district members. There were over 100 in attendance at Queenston Heights. Mrs. E. Lynn presided over the meeting and Mrs. E. Metler was in charge of arrangements for the event.

#### **DISTRICT 5**

##### **TORONTO**

##### *General Hospital*

J. McKay has returned to the staff as an instructor in the surgical division. She recently completed postgraduate study at the University of Western Ontario. J. Ives, M. Markle, B. Morrison and M. Drew attended the Biennial Convention. L. McKinnon has accepted the position of residence supervisor. D. (Nichol) Rotz is a plant nurse with General Electric while N. (Gammon) White holds a similar position

## **FOR SALE**

### **ELMIRA PRIVATE HOSPITAL**

Excellent opportunity for someone interested in operating an established business. Equipped throughout for sixteen (16) patients.

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**ELMIRA PRIVATE HOSPITAL, ELMIRA, ONTARIO**



# GRADUATE NURSES

Considering locating in Metropolitan Toronto

Enquire now concerning September & October appointments in enlarged new 125-bed suburban Toronto hospital. Advantages offered include:—

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- Attractive residence accommodation, if desired.
- Appointment to service of your choice.
- Good personnel policies with above average salary schedule.

Supervisors — \$260 increasing to \$310

Head Nurses — \$245 increasing to \$295

General Duty — \$225 increasing to \$275

Extra allowances for postgraduate training.

Apply Director of Nursing:

**HUMBER MEMORIAL HOSPITAL, 200 CHURCH ST., WESTON  
TORONTO 15, ONTARIO**

with McLean-Hunter. B. Hudson plans to work in England. N. Lee is head nurse on Ward G, female division. L. Roberts and J. Enright have completed postgraduate study at U. of T. and returned to staff positions. A. Powell is presently in England taking a course in midwifery. N. Westgate has gone to the North West Territories for a 3-year period. She will be stationed first at Copernicus for a few months before assuming the position of matron of St. Luke's Hospital, Pangnirtung, Baffin Island. J. Shears has joined the R.C.N. and is stationed at H.M.C.S. Naden, Esquimalt, B.C. G. Walker returns to McGill University this fall to complete postgraduate study before resuming her duties with the R.C.N. F. McGarry is doing industrial nursing with the Christie Bread Co.

## *Western Hospital*

G. Sharpe and G. Saunders attended the Biennial Convention in June. M. Steed recently assumed her duties as assistant director of nursing service at the Kitchener-Waterloo Hospital. M. Thomas retired early in the year to her home in Newmarket. J. MacDonald has enrolled for postgraduate study at McGill University.

## *Women's College Hospital*

Approximately 114 honored guests and alumnae members enjoyed the annual party

for the graduating class of 1956. S. Shepard proposed the toast to the graduates and the reply was given by D. Stephenson. Mrs. G. Graham brought greetings from the Board of Governors and Dr. M. Davis from the medical staff. The classes of '30, '31 and '32 enjoyed a reunion weekend earlier this year. A buffet supper at Vi (Kidd) Slater's home, a supper party at Grace (Varley) Reynolds, a tour of the new wing of the hospital and Burton Hall, and social evening were greatly enjoyed by all attending.

The class of '40 also enjoyed a reunion of nine of their members. Helen (Angus) Christie was a guest of honor. A. (Davis) Derbyshire is presently taking a refresher course at Buffalo General Hospital. E. (Thomas) Foster has returned to Canada from Rhodesia on furlough.

## **SASKATCHEWAN**

### **SASKATOON**

## *St. Paul's Hospital*

A construction grant from the federal and provincial governments has made possible completion of the top floor of the school of nursing. This will make provision for 30 bedrooms for student nurses, an extra classroom, a demonstration room and increased library facilities. It is hoped that the project will be completed before the arrival of the fall class of students.



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Good Pay with Advancement

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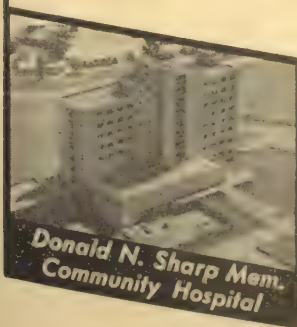
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Closing date for copy and cancellations: 10th of the month preceding the month of publication. All letters should be addressed to: The Canadian Nurse, 1522 Sherbrooke St. W., Montreal 25, Que.

**Superintendent of Nurses (1).** Salary: \$275 per mo. **Graduate Nurses (2).** Salary: \$225 per mo. less \$40 per mo. room, board & laundry. 28-bed hospital, pleasant surroundings, 5 mi. from U.S. border. 40-hr. wk., 4 wk. vacation after 1 yr. service. 1½ days sick leave per mo., yearly accumulative. Nice nurses' residence. Apply The Grands Forks Community Hospital, Grand Forks, B.C.

**Matron** for 26-bed, 4-bassinette hospital. Duties to commence Nov. 1 or earlier. Staff of 9. Salary \$275-\$325. Residence accommodation \$15 per month; board \$35 per month or .50 cents per meal. 28 days vacation after 1 yr. B.C. registration required. Located at beautiful Pender Harbor, 4 hrs. from Vancouver by thrice daily bus. Apply, enclosing photo and giving details of age, training, qualifications and experience to Administrator, St. Mary's Hospital, Garden Bay, Irvine's Landing P.O., B.C.

**Director of Nurses** for 38-bed hospital. Situated on Hope-Princeton highway. Suite in nurses' home and board, \$45 per month inclusive. Excellent bus and train service to Vancouver. Apply, stating salary expected to Administrator, General Hospital, Princeton, B.C.

**Superintendent of Nurses** for modern 80 bed hospital required immediately. Operating room Supervisor & Registered Nurses for general duty. Good personnel policies and salary for fully qualified nurses. Apply, stating qualifications and experience, to Administrator, Portage Hospital District No. 18, Portage La Prairie, Man.

**Superintendent of Nurses for 53-bed hospital.** Fully accredited & offering ideal working conditions to a qualified Registered Nurse. Salary: \$225 plus full maintenance & apt. in new nurses' residence. Excellent personnel policies. 1 mo. annual vacation. Apply Secretary, Kentville Hospital Assoc., Kentville, Nova Scotia.

**Superintendent (Sept. 1, 1956 or before) for modern 50-bed Community Hospital, 50 mi. from Ottawa.** Full maintenance. 1 mo. vacation with pay after 1 yr. service. 7 statutory holidays. Apply stating qualifications & references to Sec. to the Board, Pontiac Community Hospital, Shawville, Que.

**Matron & General Duty Nurse for 8-bed hospital.** Salaries: \$265 & \$235 gross with 6, \$5.00 increases every 6 mo. \$25 maintenance in separate nurses' residence. 8-hr. shifts. 1 mo. vacation. Sick leave. Apply Sec. Treas., Kyle-White Bear Union Hospital, Kyle, Sask.

**Matron (1) \$230 per mo. General Duty Nurses (2), \$200 per mo., with full maintenance for 20-bed hospital.** Modern nurses' home. Usual holidays with pay & sick leave, etc. Apply to Matron, Union Hospital, Vanguard, Sask.

**Supervisor for Pediatrics Dept.** with postgraduate course or equivalent. Contract conforms with R.N.A.B.C. personnel practices. Apply Director of Nurses, General Hospital, Chilliwack, B.C.

**Registered Nursing Supervisor (experienced) for modern 47-bed General Hospital serving district of 10,000.** Starting salary: \$300 per mo. Private accommodation in new nurses' residence, Board & room \$50. Nursing staff of 26 enjoying advanced personnel policies & benefits. Please state age, qualifications & references to Administrator, G. R. Baker Memorial Hospital, Quesnel, B.C.

**Operating Room Supervisor** for 110-bed hospital. Apply, Superintendent, Charlotte County Hospital, St. Stephen, N.B.

**Night Supervisor, Evening Supervisor & Staff Nurses for small hospital.** Full maintenance provided in new residence. Apply Supt., Niagara Hospital, Niagara-on-the-Lake, Ontario.

**Supervisors & Staff Nurses.** Good salary & personnel policies. Living accommodations available. Apply Director of Nurses, General Hospital, Parry Sound, Ontario.

**Hospital Supervisor for 100-bed active General Hospital.** Rotating afternoon & night shift. Blue Cross. Statutory holidays. 4 wk. vacation & 2 wk. sick leave with pay after 1 yr. service. Accommodation in residence if desired. Apply stating experience & age to The Director of Nursing, Cottage Hospital, Pembroke, Ont.

**Operating Room Supervisor for modern General Hospital with 5 operating rooms.** Located in attractive Shakespearean Festival city of 20,000. Salary according to experience. Excellent personnel policies, pleasant surroundings & congenial residence atmosphere. Apply Director of Nursing, General Hospital, Stratford, Ont.

**Night Supervisor, Assistant Head Nurses & Staff Nurses.** Excellent personnel policies. Apply Director, Shriner's Hospital for Crippled Children, 1529 Cedar Ave., Montreal, Que.



**McKellar General Hospital, Fort William, Ont. requires Registered General Duty Nurses.** Good personnel policies. Residence accommodation available at reasonable rates. Hospital has recently completed a well equipped & staffed wing with extensive renovation program progressing in the old section. Apply Director of Nursing.

**Instructor** for school of nursing — Applications are invited for 138-bed hospital. This school is affiliated with Montreal hospitals, the teaching schools associated with McGill University. For particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

**Registered Nurses.** Single room residence. \$225 per mo. gross. 5 day wk. 20 mi. east of Toronto. Apply Supt. Ajax & Pickering General Hospital, Ajax, Ont.

**Registered Nurses (2)** for new 30-bed hospital. Apply Matron, Creston Valley Hospital, Creston, British Columbia.

**Registered Nurses.** Gross salary for nurses currently registered in Ont. \$235 per mo. Good personnel policies. New facilities. Comfortable nurses' residence. 8-hr. rotating shift. 44-hr. wk. 1 day off 1 wk., 2 the next. 1½ days holiday allowed per mo. same sick time accumulated to 90 days. 8 legal holidays per yr. The equivalent of single train fare paid up to \$40 after 1 yr. service. Apply Supt., Lady Minto Hospital, Cochrane, Ont.

**Registered General Duty Nurses** for new 58-bed hospital situated in North Western Ontario. Opening about Sept. 1, 1956. Salary: \$227 per mo. subject to increase after 6-mo. with regular annual increase thereafter. \$45 per mo. room & board. 30 days vacation & rail fare refunded after 1 yr. service. New 21-bed nurses' residence, each room having an adjoining bathroom. Apply stating age & when available to Frederick Taylor, Administrator, Dist. General Hospital, Dryden, Ont.

**Registered General Duty Nurse for 35-bed hospital.** Salary: \$200 plus full maintenance. Apply Superintendent, Little Long Lac Hospital, Geraldton, Ontario.

**Registered Nurses for General Duty.** Initial salary: \$200 per mo.; with 6 or more months Psychiatric experience, \$210 per mo. Salary increase at end of 1 yr. 44-hr. wk.; 8 statutory holidays, annual vacation with pay. Living accommodation if desired. For further information apply Supt. of Nurses, Homewood Sanitarium, Guelph, Ont.

**Registered General Duty Nurses (3) for new modern 30-bed hospital.** New residence. Situated on Georgian Bay. Apply Superintendent of Nurses, General Hospital, Meaford, Ontario.

**Registered General Duty Nurses for 200-bed hospital in the Niagara Peninsula.** Gross salary \$215, afternoons — \$225, nights — \$220. Annual increments. 44-hr. wk. 3-wk. vacation per yr., 8 statutory holidays. Cumulative sick leave. Accommodation available in attractive residence. Apply Director of Nursing, County General Hospital, Welland, Ont.

**Registered Nurses** for 28-bed general hospital 48 mi. southwest of Montreal. Gross salary. \$200 per mo. Three \$5 increases at 6 mo. intervals to maximum \$215. 1 mo. annual vacation; all statutory holidays; 2 wks. sick leave; Blue Cross paid. Full maintenance available, \$35 per mo. Apply, Mrs. M. G. Curran, County Hospital, Huntingdon, Que.

**Reg'd. Nurses for modern 60-bed General Hospital situated 40 mi. south of Montreal.** Salary: \$200 per mo., additional monthly bonus for permanent evening & night shifts. 44-hr. wk., 8-hr. duty. Many attractive benefits provided. Board & accommodation available at minimum cost in completely new motel-style nurses' residence. Apply Supt., Barrie Memorial Hospital, Ormstown, Que.

**Registered Nurses** for 82-bed accredited hospital. Salary: \$225-\$245 per month. 41-hr. wk. No split shifts. 30 days paid holiday after 1 year service. Statutory holidays. Accommodation in nurses' residence and laundry of uniforms, \$8-\$12 monthly. Apply Superintendent of Nurses, Union Hospital, Canora, Sask.

**Registered Nurses (2) for modern 8-bed hospital immediately.** Salary: \$240 per mo. Full maintenance \$30 per mo. Apply B.E.I. Magnusson, Box 11, Hodgeville, Saskatchewan.

**Registered Staff Nurses (Immediately) for 220-bed hospital, including new finely equipped wing.** Duty assignments in Obstetrical, Medical & Surgical Units. Gross starting salary: \$220. Good personnel policies. Paid vacations, sick leave, pension plan. Apply Director of Nursing Union Hospital, Moose Jaw, Sask.

**Registered Nurses. Male & Female.** Starting salary: \$300 up, plus \$10 pm shifts. 40-hr. wk., paid vacation, 10 days sick leave. Social Security, hospital group ins. Apply Mr. Glenn A. Dickau, R.N., Administrator, Memorial Hospital, Corning, California.

**Registered Nurses (under age 50) General Duty — \$330 per mo. Head Nurse — \$345 to \$360 per mo.** Evening & night differentials. Retirement plan, sick leave benefits. 3 wk. vacation, 11 holidays. Modern nurses' residences. State eligibility for California registration & submit photo to Director of Nurses, Tulare-Kings Counties Hospital, Springville, California.

**Registered General Duty Nurses for 118-bed General Hospital along the shores of Lake Michigan, 25 mi. from Chicago.** Base salary: \$300. Additional differential of \$30 for evenings & \$20 for nights. 5 day wk. Good personnel policies. Apply Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

**Registered Nurses for Medical-Surgical, Psychiatric, Obstetrical & Pediatric Units, 325-bed, air-conditioned hospital.** Starting salary: \$265 with bonus for evening & night duty. 40-hr. wk. Liberal personnel policies, low cost cafeteria, free laundry. Apply Director of Nursing, Menorah Medical Center, 4949 Rockhill Rd., Kansas City, Missouri.

**Registered Nurses for 398-bed J.C.A.H. non-sectarian research & teaching hospital with N.L.N. fully accredited school of nursing.** Liberal personnel policies include tuition aid for study at Western Reserve University. Housing available at reasonable rates. Apply Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th St., Cleveland 6, Ohio.

**General Duty Nurses (3) immediately for 30-bed hospital.** Located in a good town 80 mi. east of Calgary on the CPR main line & the Trans Canada Highway. Salary: \$170 per mo. with full maintenance. Increase every 6 mo. 48-hr. wk. 8-hr. rotating shift. Apply by letter or wire for details of our staff plan to Mrs. H. Hislop, Matron, Municipal Hospital, Bassano, Alta.

**General Duty Nurses and Nursing Aides.** Active 700-bed general hospital. From September 1. Good working conditions. Personnel policies upon request. For further particulars apply to Director of Nurses, Royal Alexandra Hospital, Edmonton, Alta.

**General Duty Nurse \$232.50; Operating Room Nurse (1) for 70-bed hospital.** Starting salary: \$252.70 with increments. 40-hr. wk., 28 days vacation plus 10 statutory holidays, 1½ days sick leave monthly. Fare from Vancouver paid after 6 mo. & full board deduction of \$25. Apply Matron, St. George's Hospital, Alert Bay, B.C.

**General Duty Nurses for 110-bed General Hospital** situated in the beautiful Fraser Valley, 68 mi. from Vancouver. Good bus service. Salary: \$230 per mo. Personnel policies in accordance with R.N.A.B.C. agreement. 40-hr. wk. Residence accommodation. Apply Director of Nursing, General Hospital, Chilliwack, B.C.

**General Duty Nurses.** Salary: \$230-270, \$10 increment for experience. 40-hr. wk. 1½ days sick leave per mo. cumulative; 10 statutory holidays, 1 mo. vacation. Must be eligible for B.C. registration. Apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

**General Duty Nurses (3) Immediately for 27-bed Community Hospital.** Salary: \$230 per mo. with annual increments of \$5.00 per mo. 40-hr. wk. 28 days vacation after 1 yr. service. All statutory holidays paid. Room, board & laundry \$40 per mo. Apply, giving full details, Matron, Slokan Community Hospital, New Denver, B.C.

**General Duty Nurses for 430-bed hospital; 40-hr. wk.** Statutory holidays. Salary \$235-268. Credit for past experience. Annual increments; cumulative sick leave; 28 days annual vacation; B.C. registration required. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

**General Duty Nurses for new 150-bed general hospital.** Starting salary for registered nurses: \$230 per mo.; 4 annual increments to \$40. 28 days vacation; 10 statutory holidays. 1½ sick days per mo. cumulative. Residence accommodation, \$20 per mo. Apply, Director of Nursing, Trail-Tadanac Hospital, Trail, B.C.

**Royal Jubilee Hospital, Victoria, B.C.** invites applications for **General Duty Nurses** for permanent positions & vacation relief in 500-bed General Hospital. Salary \$227.50-\$262.50 5-day, 40-hr. wk. 4-wk vacation. 10 statutory holidays. Pension plan. Attractive employee benefits. Apply, Director of Nursing.

**General Staff Nurses for 400-bed Medical & Surgical Sanatorium,** fully approved student affiliation & postgraduate program. Full maintenance. Recreational facilities. Vacation with pay. Sick benefits after 1 yr. Blue Cross coverage. Attractive salary; 40-hr. wk. For further particulars apply Supt. of Nurses, Nova Scotia Sanatorium, Kentville, N.S.

**General Duty Nurses for 35-bed hospital, 50 mi. from Toronto.** Salary: \$200 less \$30 for full maintenance. 8-hr. duty. Good personnel policies & accommodation in home-like residence. Please furnish references & apply Supt., Stevenson Memorial Hospital, Alliston, Ont.

**General Duty Nurses (All Departments) for New Wing opening in October.** Good personnel policies. For further information apply Director of Nursing, General Hospital, Belleville, Ontario.

**General Duty Nurses for Medical, Surgical, Pediatrics, Obstetrics.** Good salary & personnel policies. Apply Director of Nursing, Victoria Hospital, London, Ont.

**General Duty Nurses for all departments.** Gross salary: \$210 per mo. if registered in Ontario \$200 per mo. until registration has been established. \$20 per mo. bonus for evening or night duty; annual increment of \$10 per mo. for 3 yrs. 44-hr. wk., 8 statutory holidays, 21 days vacation & 14 days leave for illness with pay after 1 yr. of employment. Apply: Director of Nursing, General Hospital, Oshawa, Ont.

**General Duty Nurses (3), O.R. Scrub Nurse for new 143-adult bed plus 30-bassinette hospital.** Good personnel policies. Starting salary: \$215 per mo. Apply Director of Nurses, Plummer Memorial Hosp., Sault Ste. Marie, Ontario.

**Nursing Staff.** Applications are being accepted for positions in all nursing depts. for the new Sydenham District Hospital which is due to open in September. Excellent personnel policies. Apply Director of Nursing, Sydenham District Hospital, Wallaceburg, Ontario.



**General Duty and Operating Room Nurses** for tuberculosis hospital. Personnel policies as recommended by A.N.P.Q. Apply, stating age, training and experience, to Director of Nursing, Grace Dart Hospital, 6085 Sherbrooke St. East, Montreal.

**General Duty Nurses (2) for 20-bed hospital.** Salary: \$230 per mo. for Sask. R.Ns., & \$210 per mo. for non Sask. R.Ns. 6 increments of \$5.00 per mo. every 6 mos. less \$30 for full maintenance. Apply Mrs. L. I. Walton, Supt., Nokomis Union Hospital, Nokomis, Sask.

**Staff Nurses for 600-bed General & Tuberculosis Hospitals with student programs.** In central valley, city of 108,000. State & Junior Colleges afford opportunity for advanced education. Salary \$300 with 4 annual increases to \$341. Full maintenance \$45 per mo. Liberal personnel policies. Apply Assoc. Director of Nursing Service, County General Hospital, Fresno, California.

**General Duty Nurses** for 650-bed teaching hospital in central California. Salary: \$288-\$337 per mo. 40-hr. wk. Liberal vacation, holiday & sick leave plan. Apply Personnel Office, 510 E. Market St., Stockton, California.

**Staff Nurses for 500-bed General Hospital.** Beginning salary: \$300 per mo. with advancement to \$335 for those eligible for registration in the state of Michigan. Additional differential \$1.50 per afternoon or night. 40-hr. wk. Hospital & school of nursing fully approved. Apply Director of Nursing, The Grace Hospital, 4160 John R. St., Detroit 1, Michigan.

**General Staff Nurses (3) for 80-bed General Hospital with early promotion to supervisory positions possible.** Starting salary: \$332 per mo. 8-hr. day, 5-day wk. Pay for overtime work. Vacation: 2 wks. after 12 mos., after 5 yrs., 3 wks. Sick leave. Ultra modern nurses' home. Board & room \$40 per mo. Apply Director of Nursing, Sidney A. Sumby Memorial Hospital, 234 Visger Ave., River Rouge, Michigan.

**Staff Nurses** for new hospital now being completed. Salary: \$3700-\$4200 yearly; meals and laundry provided. Excellent personnel policies. Liberal vacation: statutory holidays; civil service benefits; sick time. Apply, Director of Nursing, Martland Medical Center, Newark 7, New Jersey or phone Mitchell 3-8800.

**General Staff Nurses (all departments)** for 340-bed hospital conveniently located near New York City. Beginning salary: \$260 per mo. \$30 bonus for 2:30-11 P.M. \$20 for 10:30 P.M.-7 A.M. Extra bonus for Operating & Delivery rooms. Increments every 6 mo. for 5 yrs. 40-hr. 5-day wk. 1 meal & laundering of uniforms gratis. Living quarters available at moderate cost. Excellent personnel policies. Overtime pay. 4 wk. vacation after 1 yr. 8 paid holidays. Sick time cumulative to 60 days. In-Staff educational program. Blue Cross ins. Pleasant working surroundings. Apply Director of Nursing Service, Presbyterian Hospital, Newark, New Jersey.

**Graduate Nurses (2)** for general duty. Salary: \$250 per mo. 8-hr. day, 5-day wk. Room & Board \$45 per mo. Transportation paid one way after 6-mo. service. Apply Matron, Queen Charlotte Islands Hospital, The United Church of Canada, Queen Charlotte City, B.C.

**Graduate Nurses (3)** for 24-bed hospital. Salary: \$230 per mo. if B.C. registered; less \$40 board, lodging, laundry. 1 mo. vacation after 1 yr. on full pay. 1½ days sick leave per mo. cumulative. Apply, stating experience to Matron, Terrace & District Hospital, Terrace, British Columbia.

**Graduate Nurses (General Staff Positions)** for General Hospital. Salary: \$235.50 per mo. as minimum & \$273.75 as maximum, plus shift differential for evening & night duty. 40-hr. wk. Temporary residence accommodation is available. Applicants not registered in B.C. should forward a letter of acceptance of registration in B.C. from the Registrar of Nurses, 2524 Cypress St., Vancouver, B.C. Please apply Personnel Dept., Vancouver General Hospital, Vancouver, B.C.

**Graduate Nurses & Dietician (1)** for new, very modern 88-bed hospital in a pleasant progressive town. Nurses salary: \$200 per mo. Annual increase \$10 per mo. for 3 yrs. 2-wk. shift rotation, bonus for night shifts. 1 hr. drive to Toronto & several resorts. Local swimming pool, bowling alleys, skating, theatres etc. Apply Director of Nurses, Dufferin Area Hospital, Orangeville, Ont.

**Graduate Nurses** for duty on Obstetrical, Medical & Surgical Wards. Personnel policies as recommended by the Assoc. of Nurses of the Prov. of Quebec. Please apply Director of Nursing, Queen Elizabeth Hospital of Montreal, 2100 Marlowe Ave., Montreal 28, Que.

**Operating Room nurse.** Postgraduate training not essential. A.N.P.Q. salary scale in effect. All graduate staff. 8-hr. day; 5½ day wk. Apply Director of Nursing, Montreal Children's Hospital, Montreal, Que.

**Operating Room & Staff Nurses for 227-bed Pediatric Hospital in sunny California.** Salary: \$300 per mo. with differential for Operating Room & evening & night duty. 5-day, 40-hr. wk. Liberal personnel policies including vacation, sick time & retirement. Apply Director of Nursing, Childrens Hospital Society, 4614 Sunset Blvd., Los Angeles 27, California.

**Registered or Licensed Practical Nurse.** Starting salary: \$175 per mo. for R.N. \$110 for practical. Full maintenance & living-in privileges included 5 annual increments of \$5.00 per mo. Apply John Hiscock, Sec.-Treas., Baldur Medical Nursing Unit, Baldur, Man.



**Supervisor (qualified.)** Good salary. Extra allowance for experience if French speaking. 5-day wk., 4-wk. vacation, 18 days sick leave cumulative annually. Car is provided. Half cost of uniform is allowed & half of Blue Cross. Workmen's Compensation. Good working conditions. Apply Sec.-Treas., Porcupine Health Unit, 164 Algonquin Blvd. E., Timmins, Ont.

**Public Health Nurse (Qualified).** For Health Unit serving area around Lethbridge, Alberta. Salary \$2640-\$3180. Usual employee benefits of holiday leave, sick leave, hospitalization and participation in pension plan. Apply to Medical Officer of Health, Barons-Eureka Health Unit, Coaldale, Alta.

**Public Health Nurse** for the Municipality of Oak Bay, Vancouver Island, B.C. (adjoining Victoria). Duties to commence in September. Salary in accordance with provincial scale plus monthly car allowance. Should own a car. Apply, stating age, qualifications, experience and submit references to the Municipal Clerk, Municipal Hall, Oak Bay, B.C.

**Public Health Nurse Grade 1.** British Columbia Civil Service, Dept. of Health & Welfare. Starting Salary \$255, \$260, \$266 per mo., depending on experience, rising to \$298. per mo. Promotional opportunities available. Qualifications: Candidate must be eligible for registration in British Columbia & have completed a University degree or Certificate course in Public Health Nursing. (Successful candidates may be required to serve in any part of the Province.) Cars are provided. 5-day wk. in most districts. Uniform allowance. Candidates must be British subjects; preference is given to ex-service women. Application forms obtainable from all Government Agencies, the Civil Service Commission, 544 Michigan St., Victoria, or 411 Dunsmuir St., Vancouver 3, to be completed & returned to the Chairman, Civil Service Commission, Victoria. Further information may be obtained from the Director, Public Health Nursing, Dept. of Health & Welfare, Parliament Bldgs., Victoria, B.C.

**Public Health Nurses for Kent County Board of Health Unit.** Minimum salary: \$2,840 with annual increases of \$150 per yr. for 4 successive years. 38-hr. wk. 3 wks. vacation with pay. All statutory holidays. 2 days a mo. sick leave accumulative to 48 days. Uniforms provided. Ideally located, bordered on the south by Lake Erie & by Lake St. Clair on the west. The city of Chatham being located in the centre of the county with the cities of London, Sarnia & Windsor, Ont. & the city of Detroit, Mich. all within 1 hr. drive making Kent County a most desirable place in which to live & make a living. Apply W. M. Abraham, Sec.-Treas., Kent County Board of Health, 7th St., Chatham, Ont.

**Public Health Nurses** for generalized program, bedside nursing included. Rural area. Blue Cross & group ins. available. Good transportation policy. 4-wk. vacation after 1 yr., statutory holidays. Apply Dr. J. I. Jeffs, Lennox & Addington County Health Unit, Napanee, Ont.

**Public Health Nurse (1) for generalized program** in rural & semi-urban area adjacent to metropolitan Toronto. Excellent working conditions including pension plan, group ins. & transportation arrangements. Apply Dr. R. M. King, York County Health Unit, Newmarket, Ont.

**Public Health Nurses (Qualified) for City of Oshawa.** 4 vacancies. Generalized program in urban area. Starting salary without experience: \$3,100. Annual increment \$120. Transportation provided. 5-day wk. Pension & hospitalization plans available. Apply A. F. Mackay M.D., Medical Officer of Health, City Hall, Oshawa, Ont.

**Public Health Staff Nurses (2) for generalized program** in city of 43,000. Blue Cross & P.S.I. employer shared. Transferrable accumulative sick leave & pension plans. Workmen's Compensation. Group ins. available. Transportation provided or allowance — 10¢ first 2,000 mi., 8¢ per mi. thereafter. 5-day wk. 1 mo. vacation with extra time at Christmas. Salary scale: \$3,000 for inexperienced nurses to start with annual increments of \$150. All starting salaries dependent on experience. For further information please write supplying details of training & experience to Medical Officer of Health, City Hall, Peterborough, Ont.

**Public Health Nurse (Qualified) Duties to commence at once.** Salary & conditions of employment in accordance with Registered Nurses' Association of Ontario. Apply J. H. Eakins, Clerk of the Town of Strathroy, Strathroy, Ontario.

**Public Health Nurses (qualified.)** Salary: \$3,100 depending on dist. served, less if in the Timmins area. Annual increment \$150 per annum for 4 yrs. Additional allowance for experience & if French-speaking. 5-day wk. 4-wk. vacation, 18 days sick leave annually (cumulative.) Car is provided. Half cost of uniform is allowed & half of Blue Cross. Workmen's Compensation. Good working conditions. Apply Sec.-Treas., Porcupine Health Unit, 164 Algonquin Blvd. E., Timmins, Ont.

**Public Health Nurse (Qualified)** for expanding program in growing suburban municipality. Min. salary \$3,200 with regular annual increments to \$3,680. Further increases by merit rating. Starting salary based on experience. Car allowance \$670 per yr. 4 wks. vac. after 1 yr. Blue Cross and pension plan. For further details apply, Personnel Director, Township of Etobicoke, 4941 A Dundas Street W., Toronto 18. Tel. BE 1-4161.

**Graduate Nurse (experienced),** capable of assuming position of Superintendent of Nurses in new, modern, 25-bed hospital. Required immediately. **Graduate nurses (2)** to complete staff. Salary scale according to R.N.A.B.C. policies. Board & room, \$35 per mo. Apply, Administrator, Lady Elizabeth Bruce Memorial Hospital, Invermere, B.C.

**Graduate Nurse for 18-bed General Hospital, situated on the beautiful Arrow Lakes.** Standard salaries. Holidays. 40-hr. wk. Apply Matron, Arrow Lakes Hospital, Nakusp, B.C.

## **OPERATING ROOM SUPERVISOR ASSISTANT OPERATING ROOM SUPERVISOR**

Experienced, postgraduate preferred. This is a modern, well-equipped department. Salary commensurate with qualifications and experience.

Apply:

**PERSONNEL DIRECTOR, SARNIA GENERAL HOSPITAL, SARNIA, ONTARIO**

**Graduate Nurses** for active 52-bed hospital. Salary: \$175 per mo. with full maintenance and laundry. Increments at end of 6 mo., 1 yr; 2 yrs. 1 mo. vacation after 1 yr. service. Sick leave allowance. Situated on main line between Calgary & Edmonton. Apply, Mrs. E. Harvie, Municipal Hospital, Lacombe, Alta.

**Registered Nurses** for new 28-bed hospital in Northern Ontario. Salary: \$205 per mo. with annual increments. 44-hr. wk. 28 days annual holiday. 8 statutory holidays. Rotating shifts. Cumulative sick leave and hospital plans. New residence. Apply, Superintendent, Bingham Memorial Hospital, Matheson, Ont.

**Operating Room Supervisor and General Duty Nurses** for 43-bed General Hospital in friendly resort town. For further information, apply, Superintendent, District Memorial Hospital, Huntsville, Ontario.

**Night Supervisor.** Salary: \$2,760-\$3,300 plus cost-of-living bonus approximating \$325 per annum. Excellent holiday, sick leave and pension benefits. Apply to Baker Memorial Sanatorium, Calgary, Alberta.

**Graduate Nurses** for general staff duty in a tuberculosis hospital for treatment of adult medical patients. For further information, apply to Director of Nursing, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, P.Q.

**Laboratory technician** with knowledge of X-ray for 56-bed hospital. Pleasant working conditions. Apply Mrs. A. Kerby, Superintendent, Municipal Hospital, Stettler, Alta.

**Graduate nurses** for 56-bed hospital. Excellent working conditions. 8-hr. duty, rotating shifts. Apply Mrs. A. Kerby, Superintendent, Municipal Hospital, Stettler, Alta.

**General duty nurses** for 65-bed hospital. Gross salary: \$185-\$210. per mo. 44 hr. wk., statutory holidays. For further information apply. Director of Nursing Services, General and Marine Hospital, Collingwood, Ont.

**General duty nurses** for modern 50-bed hospital. Salary: \$195 per mo. Good personnel policies. 44-hr. wk. Full maintenance. Apply, Matron, Municipal Hospital, Vermilion, Alta.

**Registered General Duty Nurses (2) immediately for 16-bed hospital.** Starting salary: \$215 less maintenance \$30. Nurses home available. Holidays & sick leave according to A.A.R.N. Apply Sec.-Treas., Municipal Hospital #73, Smoky Lake, Alberta.

**Graduate Nurses (4) to commence duties as soon as possible.** Gross salary: \$200 per mo. less \$30 perquisites. Full maintenance. 6 mo. increments of \$5.00 per mo., maximum 3 yrs. Holidays with pay. 4-wks. for every 12 mo. service, which includes statutory holidays. 14 days sick leave for each 12 mos. service accumulative to 42 days. 44-hr. wk. Hospitalization \$1.60 per day. Write the Matron, Municipal Hospital, Three Hills, Alta.

### **THE PROVINCE OF MANITOBA**

*requires a*

### **SUPERINTENDENT OF NURSES**

for the School for Mentally Defective Persons at Portage La Prairie, Manitoba. Applicants should be qualified in Psychiatric Nursing, registered Nurse preferred.

Experience or postgraduate study in administration would be an asset. The above position offers full Civil Service benefits, liberal sick leave, four weeks' vacation annually with pay and pension privileges.

Apply stating qualifications, experience and salary expected to:

**MANITOBA CIVIL SERVICE COMMISSION**

247 Legislative Building, Winnipeg, Manitoba.



# **The Ontario Society for Crippled Children**

*requires*

**EXPERIENCED PUBLIC HEALTH NURSES**

**GOOD SALARY RANGE**

*and*

**PERSONNEL POLICIES**

*For further information apply to:*

**THE SUPERVISOR OF NURSING SERVICES,  
ONTARIO SOCIETY FOR CRIPPLED CHILDREN,  
92 COLLEGE STREET, TORONTO 2, ONTARIO**

**General Duty Nurses (2) for permanent staff of well equipped small hospital.** Salary: \$175 per mo. plus full maintenance. 5½ day wk., 8-hr. duty. Rotating shifts, long week-end following night duty. 1 mo. vacation after 1 yr. Apply Supt., Saugeen Memorial, Southampton, Ontario.

**Superintendent for new modern 25-bed hospital opening December 1, 1956.** Full maintenance. 3-wks. vacation with pay after 1 yr. service. 7 statutory holidays. Apply stating qualifications & references to Mrs. Wilfred Graye, Sec. to the Board, Tobique Valley Hospital, Plaster Rock, N.B.

**Assistant Director & Operating Room Nurse for 87-bed General Hospital in Central B.C.** Accomodation available & fare refunded after 6 mo. service. Apply stating qualifications experience & date available to the Administrator, Prince George & District Hospital, Prince George, B.C.

**Supervisor of Nursing (R.N. experienced in nursing service administration desirable) for new modern 50-bed General Hospital** in progressive town (10,000) in Cariboo Dist. central B.C. 14 R.N.'s., 10 Aides, 6 Med. staff. Priv. suite in new residence. Salary commensurate with qualifications. 40-hr. wk., 28 days vacation plus 10 statutory holidays. Sick leave. Travel allowance. Please state age, salary expected, experience & references to Administrator, G. R. Baker Memorial Hospital, Quesnel, B.C.

**Operating Room Supervisor** with special training in anesthesiology — Salary open. **Operating Room Nurses** — Salary: \$320 per mo. **Staff Nurses for Nursing Areas** — Salary: \$270 per mo. Liberal personnel policies, full maintenance provided. 40-hr. wk. 2 wks. vacation with pay after 1 yr. service. Apply Director of Nursing, White Pine County General Hospital, Ely, Nevada.

**Assistant Head Nurses & General Duty Nurses for 150-bed Communicable Disease Hospital.** Apply Director of Nursing, Alexandra Hospital, Montreal, Que.

**Registered General Duty Nurses (2) for 35-bed hospital.** Salary: \$185 per mo. plus full maintenance. 4 increments at \$5.00 per mo. after each 6 mo. 1 mo. vacation pay, sick leave & hospitalization benefits. If employed for 1 yr. a refund of train fare from any point in Canada given. Apply Miss M. A. MacDonald, Matron, Municipal Hospital, Two Hills, Alberta. Phone 335.

## **CANADIAN RED CROSS SOCIETY**

invites applications for **STAFF and ADMINISTRATIVE** positions in **HOSPITAL, PUBLIC HEALTH NURSING SERVICES, and BLOOD TRANSFUSION SERVICE** for various parts of Canada.

- The majority of opportunities are in **OUTPOST SERVICES** in British Columbia, Saskatchewan, Manitoba, Ontario, Quebec, New Brunswick, and Nova Scotia.
- Commensurate salaries for experience and qualifications. Transportation arrangements under certain circumstances. Bursaries are available for post-graduate study.

*For further particulars apply:*

**NATIONAL DIRECTOR, NURSING SERVICES, CANADIAN RED CROSS SOCIETY,  
95 WELLESLEY ST., TORONTO 5, ONTARIO.**



# REGISTERED NURSES

FOR GENERAL DUTY AND OPERATING ROOM

*opportunities available at*

## THE MONTREAL GENERAL HOSPITAL

*For further particulars write to:*

**DIRECTOR OF NURSING, 1650 CEDAR AVENUE, MONTREAL 25, P.Q.**

**Registered General Duty Nurses.** Starting salary: \$225 per mo. maximum, \$255. Annual increment \$120. Board & room available in new nurses' residence \$45 per mo. Blue Cross coverage paid by hospital. Transportation costs remitted after 6 mo. Apply Matron, General Hospital, Atikokan, Ont.

**Registered General Duty Nurses for beautiful new 112-bed modern hospital opening immediately.** Advancement to supervisory positions for early applicants. Salary: \$310 to start. Merit increases. 40-hr. wk. Annual vacation, paid holidays. Sick leave, group ins. Dynamic, lovely California city. Write full particulars to Director of Nurses, Greater Bakersfield Memorial Hospital, 420, 34th St., Bakersfield, California.

**Public Health Nurse (Qualified) for senior position,** generalized Public Health Nursing. Salary: \$3,750 per yr. 5-day wk. Sick pay benefits Blue Cross, P.S.I. Car allowance. Apply J. H. Miller, Municipal Clerk, Town of New Toronto, 185 Fifth St., New Toronto, Ont.

**Wentworth County Health Unit requires Public Health Nurses.** Salary schedule: \$3,000-\$3,600. 5-day wk. 4 wk. vacation with pay. Blue Cross & medical plan available. Pension plan, sick leave credits. Liberal car allowance, loans on purchase of car available. Apply giving experience & qualifications to A. F. Stewart, National Revenue Bldg., Hamilton, Ont. Phone JA. 8-2581.

**Medical Secretary for medical dept.** firm of manufacturing chemists, West end of city. 2 or 3 yrs. experience secretarial work with nursing background. Canteen on premises. 5-day wk. Salary commensurate with ability. Apply Personnel Dept., Merck & Co. Ltd., P.O. Box 899, Montreal 3, Que.

**Operating Room Nurses (2) for 60-bed General Hospital.** Good salary. 5½ day wk. Statutory Holidays. Apply Supt., Leamington District Memorial Hospital, Leamington, Ont.

**Surgical Nurse (Full time position) for small hospital in San Joaquin Valley of California.** Wonderful climate, 2 hrs. from San Francisco & mountain resorts. Good salary & pleasant working conditions. Will also welcome applications for **General Duty Nurse.** Apply Administrator, Lillian Collins Hospital, 330 Crane Ave., Turlock, California.

**Director of Nursing for approx. 100-bed hospital with School of Nursing (30-40 students.)** Initial salary: \$250-\$300 per mo. depending on qualifications & experience. Qualifications desired: Degree or postgraduate certification in nursing service & school of nursing administration & some experience. Perquisites: Private 3-room apt. in residence; full maintenance & laundry provided. Apply with references to Chairman, Personnel committee, Victoria Hospital, Renfrew, Ontario.

## GENERAL STAFF NURSES

For 526-bed General Hospital with opportunity for advancement. Rotating or permanent day, evening & night assignments. 40-hr. wk. 6-hr. evening duty. Salary \$270 to \$310 with planned merit increases. Substantial evening & night bonus. Tuition assistance for university & college courses. On duty time may be arranged to accommodate college schedules. 2 wk. vacation after 1 yr. of service, 3-wk. after 2 yrs. 5-10 days paid sick leave. Uniforms laundered. Temporary housing available in the hospital residence at a nominal fee. Convenient public transportation.

*Apply:*

**DIRECTOR OF NURSING SERVICE, SAINT LUKE'S HOSPITAL, 11311 SHAKER BLVD.,  
CLEVELAND 4, OHIO**

## **PEDIATRIC INSTRUCTOR**

Responsible for classroom and clinical instruction in pediatric nursing & co-ordinating maternal & child care program in school where organizational set-up permits stressing of patient-centred care and student-centred learning activities.

*For further information apply:*

**DIRECTOR, SCHOOL OF NURSING, METROPOLITAN GENERAL HOSPITAL, WINDSOR, ONTARIO.**

## **REQUIRED IMMEDIATELY**

**Head Nurse, Nursery  
(Postgraduate experience preferred)  
General Staff Nurses, All departments  
(\$225 per mo. plus laundry)**

New 300-bed General Hospital. Excellent Personnel Policies.

*For further information apply:*

**Director of Nursing, Memorial Hospital, Regent St. S., Sudbury, Ontario.**

## **REGISTERED NURSES**

**\$2,610-\$3,360**

## **CERTIFIED NURSING ASSISTANTS**

**\$2,040-\$2,220**

**SUNNYBROOK HOSPITAL  
TORONTO**

**WESTMINSTER HOSPITAL  
LONDON**

Application forms, available at your nearest Civil Service Commission Office, National Employment Service & Post Offices, should be forwarded to the

**CIVIL SERVICE COMMISSION,  
25 ST. CLAIR AVE. E., TORONTO 7, ONTARIO**

## **GENERAL STAFF and PSYCHIATRIC NURSES**

*Required to staff*

New wing of 350-bed General Hospital.

Basic salary: \$250 per mo. with yearly increments of \$120 for 3 years.

Differential for evening & night duty.

*For further information apply to:*

**DIRECTOR OF NURSING SERVICES, METROPOLITAN GENERAL HOSPITAL  
1995 LENS AVENUE, WINDSOR, ONTARIO**

## **GRENFELL LABRADOR MEDICAL MISSION**

The Grenfell Mission requires a Laboratory Technician, Occupational Therapist and Nurses for their headquarters at St. Anthony, Newfoundland. These are positions which combine work in a modern hospital with the opportunity for service to the people of the Canadian Northland.

For full information please write:

**MISS DOROTHY A. PLANT, SECRETARY**

**GRENFELL LABRADOR MEDICAL MISSION, 48 SPARKS ST, OTTAWA 4, ONTARIO**

### **PROVINCE OF NOVA SCOTIA DEPARTMENT OF PUBLIC HEALTH, REQUIRES NURSES**

Applications are invited from Graduate Nurses with or without public health training for positions in the Division of Public Health Nursing, Department of Public Health, Nova Scotia. Bursaries available for training. Salary dependent on training and experience.

*For further information and application forms  
apply to*

**DIRECTOR OF  
DIVISION OF PUBLIC HEALTH NURSING  
DEPARTMENT OF PUBLIC HEALTH  
PROVINCIAL BUILDING  
HOLLIS STREET, HALIFAX, N.S.**

*or*

**NOVA SCOTIA CIVIL SERVICE COMMISSION  
P.O. BOX 943, HALIFAX, N.S.**

### **REGISTERED NURSES NURSING ASSISTANTS ORDERLIES**

**Required for all Departments in  
New 150-bed General Hospital**

**Excellent Salary & Personnel  
Policies**

**Hospital scheduled to open  
August 1st, 1956**

*Apply*

**DIRECTOR OF NURSING,  
QUEENSWAY  
GENERAL HOSPITAL  
TORONTO 14, ONTARIO**

## **UNIVERSITY HOSPITAL**

**SASKATOON, SASKATCHEWAN**

*Requires*

**General Staff Nurses for Medical, Surgical, Obstetrical and Pediatric Services.  
Forty-four hour week. Salary \$220 to \$260 gross per month. Differential  
for evening and night duty, Residence Accommodation if desired.**

*Apply to:*

**DIRECTOR OF NURSING, UNIVERSITY HOSPITAL,  
SASKATOON, SASKATCHEWAN**



## **REGISTERED NURSES' ASSOCIATION OF ONTARIO**

invites applications for the position of  
**PROFESSIONAL SECRETARY IN PROVINCIAL OFFICE**

Advanced preparation and experience essential,  
preferably in nursing service administration.

*For further information, apply to:*

**MISS FLORENCE H. WALKER, GENERAL SECRETARY-TREASURER,  
515 JARVIS ST., TORONTO  
POSITION NOW OPEN**

### **NURSING INSTRUCTRESS**

(Immediately)

Registered Nurse with experience & preferably postgraduate training in Psychiatric Nursing & Nursing Instruction to teach affiliate student nurses rotating through new 25-bed psychiatric ward in the Union Hospital, Moose Jaw.

**Salary range:**

**\$288-\$350 per month.**

Application forms are available from the

**PUBLIC SERVICE COMMISSION,  
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Carnation Sterilization Process

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### **Sterilization Methods**

One step in the processing of Carnation Evaporated Milk is "classified information." This is the time-temperature relationship during the sterilization of Carnation Evaporated Milk in the can. It is this method, based on 50 years of Carnation experience, that not only renders the milk safe and sterile, but also produces the uniform, easily digested low tension curd so important in infant feeding.

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In addition to direct research, Carnation sponsors university research in highly specialized fields. A sponsored project currently under way at the Massachusetts Institute of Technology concerns the possibilities of radiation for the sterilization of evaporated milk and other dairy products.



One of the sterilization methods investigated by Carnation Research Laboratory

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956

"from Contented Cows"

# THE CANADIAN NURSE

## *L'Infirmière Canadienne*

VOLUME 52

NUMBER 10

OCTOBER 1956

- 774** NEW PRODUCTS
- 781** ARE WE EQUAL TO  
OUR FUTURE?.....*Byrne Hope Sanders*
- 785** SOMMES-NOUS EN MESURE  
DE FAIRE FACE A L'AVENIR?.....*Byrne Hope Sanders*
- 790** SIGNPOST AT GENEVA.....*Dorothy M. Percy*
- 799** TRENNA HUNTER, PRESIDENT
- 800** RADIOACTIVE ISOTOPES.....*V. Skerry, J. MacLean,  
J. Black, M. Kennedy, S. MacDonald*
- 804** NURSING PROFILES
- 806** IN MEMORIAM
- 810** THE ROLE OF THE NURSE  
IN REHABILITATION.....*Elisabeth C. Phillips*
- 820** NURSING ACROSS THE NATION
- 824** LE NURSING A TRAVERS LE PAYS
- 832** SÉLECTION
- 838** NEWS NOTES
- 840** EMPLOYMENT OPPORTUNITIES
- 856** OFFICIAL DIRECTORY

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# Between Ourselves

**O**CTOBER — the month when Eastern Canada is ablaze with the glory of fall colors; when the first snow dapples the mountain peaks in Western Canada; when we pack away our summer clothes and begin to sort out warmer apparel for the winter months. In every part of our land, directors of nursing have welcomed new classes of nurses-to-be, have arranged orientation programs for new staff members, have breathed freely again as they realized their rosters were *nearly* at full strength.

At every level, too, organizational activity is reawakening after the summer lull. Student government associations have elected their new officers, staff organizations are planning for new in-service educational programs, alumnae associations and local chapters are seriously considering the most effective means of keeping the membership interested — of ensuring their presence at meetings. There are so many counter-attractions that the right key to unlock the gate to continuing active interest and participation must be sought by the executives of all these organizations. That key is in the shape of a large double "P" — Program Planning.

With such a diversity of organizations of varying age groups, in small hospitals and large, in rural as well as urban areas, with the needs of individual nurses as mixed as the groups themselves, it would be well nigh impossible to draft a master plan of programs through your *Journal*. It is possible, however, to note some of the essentials of good program planning and hope that they may be of value in any group. Some of these items may seem very elementary to experienced program committees. We hope that others who are less accustomed to preparing a program may find them useful.

1. Programs should be planned early in the organization's year and in sufficient detail that every member can be informed well in advance. An occasional "mystery" program may tantalize a few members but if good attendance is the aim, a schedule of speakers and topics should be made available to every person early in the season.

2. Use the talent in your own association. We are so prone to think that only an outside speaker will attract a worthwhile audience. Actually nurses will flock to hear

the presentation of "clinics" describing new techniques and procedures. The experience of assembling their information and presenting it is valuable for everyone even the most modest and reserved nurse.

3. If an outside speaker is wanted, try to secure the top person in the particular field of interest. Remember, outstanding speakers are very human and they feel complimented to be invited to address a worthwhile organization. If they are too busy to accept, their refusal should never be regarded as an affront to the association.

4. Variety in topics may increase interest but consistency in following a general theme is of even greater value. The broad topic of Evaluation and Accreditation of Schools of Nursing is, for example, a very important consideration in association affairs. Exploring its various facets could provide interesting programs for several meetings. Discussions at the student nurses' sessions at the recent convention revealed how woefully ignorant the great majority of them were of what team nursing means. Where better can nurses learn about either of these developments than in their own organization?

5. In arranging the actual order for meetings, place the speaker early. If she is a member, possibly not too experienced in talking before a group, the suspense of sitting through a routine business session may be exhausting. If an outside speaker has been invited courtesy and consideration dictate that he should not be kept waiting until the very end of the agenda. If necessary, business can be resumed *after* the address and discussion period.

6. The person introducing the speaker should be prepared. Dignified and kindly introductions are a compliment to the speaker and to the person making the introduction. It should be brief, telling who, what, where, about the speaker and his or her work, and how or why about the topic. Avoid wise-cracks! After all, the speaker has half an hour or more to get even!

7. Thanking a speaker does not call for a re-hash of the address. Remarks should be simple and sincere, highlighting perhaps one or two memorable points that have been made. It is the chairman's privilege to thank the speaker herself or to designate a mem-

(Continued on page 776)

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# New Products

Edited by DEAN F. N. HUGHES

PUBLISHED THROUGH COURTESY OF *Canadian Pharmaceutical Journal*

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## ALBAMYCIN CAPSULES

**Manufacturer**—The Upjohn Company of Canada, Toronto, Ont.

**Description**—Novobiocin sodium, an antibiotic derived from *Streptomyces niveus*.

**Indications**—Treatment of the most commonly occurring gram-positive and gram-negative bacterial infections particularly those caused by *Staphylococcus aureus*, *Micrococcus aureus* and *Micrococcus pyogenes*. Especially effective when organisms have become resistant to other antibiotics.

**Administration**—Orally as prescribed.

---

## BONADOXIN

**Manufacturer**—Pfizer Canada, Montreal 9.

**Description**—Each tablet contains 25 mg. bonamine (meclizine) and 50 mg. pyridoxine hydrochloride.

**Indications**—For the prophylaxis and treatment of nausea and vomiting of pregnancy, motion sickness, radiation sickness, Menière's syndrome, cerebral arteriosclerosis, labyrinthine fenestration procedures and vestibular dysfunction.

**Administration**—Nausea and vomiting of pregnancy, initially 1 tablet at bedtime, dosage increased as indicated. Motion sickness: 1 or 2 tablets 1 hour before embarkation.

---

## COMBISTREP

**Manufacturer**—Pfizer Canada, Montreal 9.

**Description**—Sterile dry powder containing 0.5 gm. of streptomycin and 0.5 gm. dihydrostreptomycin per gram for intramuscular use.

**Indications**—For tuberculous patients requiring streptomycin therapy especially in cases necessitating prolonged therapy.

**Administration**—For intramuscular therapy only, and must not be used intrathecally or intravenously. Dosage is the same as for streptomycin or dihydrostreptomycin.

---

## CORDEX TABLETS

**Manufacturer**—The Upjohn Company of Canada, Toronto 6, Ont.

**Description**—Each tablet contains: Delta-1-hydrocortisone (prednisolone) 0.5 mg., 11B, 17A, 21-trihydroxy-1,4-pregnadiene-3,20-dione acetylsalicylic acid 300 mg.

**Indications**—Indicated in the following conditions when they are of mild to moderate severity and are not controlled by salicylates alone: rheumatoid arthritis, osteoarthritis, gouty arthritis, bursitis, tenosynovitis, myositis, fibrositis, and neuritis.

**Administration**—Usual dosage is 1 to 2 tablets four times daily, with a maximum dosage of 3 tablets 4 times daily. For optimal benefit, particularly in patients likely to require long-term treatment, the starting dose should be based on the patient's tolerance to acetylsalicylic acid. The initial dose should be continued until a satisfactory clinical response is obtained, at which time the dose should be reduced to a minimal effective level. To minimize the possibility of gastric irritation, each dose should be taken immediately after meals and at bedtime.

---

## DITHRITOL

**Manufacturer**—Paul Maney Laboratories Canada Limited, Hamilton, Ont.

**Description**—Each tablet contains: Pentaerythritol tetranitrate 10 mg., dilin (dihydroxypropyl theophylline) 100 mg.

**Indications**—Asthma, coronary spasm, prophylaxis and treatment of left ventricular insufficiency, cardiac dyspnea and oliguresis.

**Administration**—Usual dosage, 1 or 2 tablets 3 times daily.

---

## FLEET ENEMA

**Manufacturer**—Charles E. Frosst & Co., Montreal.

**Description**—Each 100 cc. of solution contains: Sodium acid phosphate U.S.P. 16 gm., sodium phosphate U.S.P. 6 gm.

**Indications**—For proctoscopy and sigmoidoscopy, preoperative cleansing and post-operative use, to relieve fecal or barium impactions, for use in collection of stool specimens, and as a routine enema.

**Administration**—Lubricate tip of the plastic rectal tube with lubricant supplied. Preferred position: Lying on left side with knees flexed, or in the knee-chest position. Maintain position until defecation impulse is felt, usually within 1 to 5 minutes. May be used at room temperature. Adults: 4 ozs. Children over 6 years: 2 ozs. Younger children: in proportion.

---

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GENERAL HOSPITAL  
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**Manufacturer**—Ingram & Bell Limited, Toronto, Ont.

**Description**—Bacterial obstetrical cream based on the incorporation of para-chlor-metaxylenol into a smooth, non-greasy, water-soluble base.

**Indications**—To reduce infections during obstetrical procedures. Also indicated for sterilizing the hands and gloves prior to digital examination.

**Administration**—Pour about one-half teaspoonful into the palm and rub the hand gently to distribute the cream evenly over the entire surface. Continue rubbing until nearly dry. Particular attention should be paid to areas under and around the fingernail.

---

## MEDIHALER-EPI

**Manufacturer**—Riker Pharmaceutical Company, Limited, Toronto 8, Ont.

**Description**—A 0.5% solution of epinephrine containing 0.1% ascorbic acid as a preservative in an inert propellant. Alcohol 33%. Packed in a specially designed vial with a metered dose valve and for use only with a Medihaler oral adapter.

**Indications**—For oral inhalation with medihaler adapter for temporary relief of the spasms and wheezing of bronchial asthma.

**Administration**—One or 2 inhalations as may be necessary for relief.

---

## PROTOVAB

**Manufacturer**—Charles E. Frosst & Co., Montreal.

**Description**—Each scored tablet contains protoveratrine A and B, 0.2 mg. or 0.5 mg.

**Indications**—Hypertension, hypertensive cardiovascular disease.

**Administration**—One to 2 tablets 2 to 4 times daily. To be used in conjunction with alserin.

---

## SERPATILIN

**Manufacturer**—Ciba Company Limited, Montreal.

**Description**—A combination of the tranquilizer, serpasil, and the mild central nervous system stimulant, ritalin. The complementary action of the two components tends to restore and maintain emotional equilibrium. Each tablet contains: Serpasil 0.1 mg., ritalin 10 mg.

**Indications**—Chronic fatigue and mild depressive states, with or without anxiety, tension syndrome; lethargy, menopausal syndrome; psychoneuroses associated with depression; and withdrawn, apathetic behavior. Effective in patients who complain of chronic nervous exhaustion, inability to think clearly, listlessness, apathy, lessened capacity for work or lack of energy, vague somatic disorders, preoccupation with self, pessimistic thoughts, anxiety, confusion, forgetfulness, frustration, hostility and irritability. In senile patients, lessens confusion or disorientation and improves behavior patterns.

**Administration**—The average dose is 1 tablet 2 or 3 times a day.

In some patients the effect of serpasil in the combination may not be immediately apparent and therapy should be continued for several days in order to obtain the full benefit.

---

## SUVREN

**Manufacturer**—Ayerst, McKenna & Harrison Ltd., Montreal.

**Description**—Each coated tablet contains 50 mg. captodiamin (p-butylmercapto-benzylhydrl-B-dimethylaminoethyl sulfide hydrochloride), a compound possessing tension-relaxing and spasmolytic effects.

**Indications**—For relaxation of nervous and emotional stress without dulling mental alertness.

**Administration**—One or 2 tablets 3 or 4 times daily, after meals and at bedtime.

---

## ZYLJECTIN AMPOULES

**Manufacturer**—Abbott Laboratories, Ltd., Montreal.

**Description**—Each 5-cc. contains: Procaine base 75 mg., butesin 0.30 gm., benzyl alcohol 0.25 gm., purified peanut oil q.s.

**Indications**—For the prolonged symptomatic relief of painful conditions in and around the anus such as fissures and pruritis.

**Administration**—5 to 20 cc. as required, injected into deep subcutaneous tissues. Superficial injection may produce sloughing.

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*(Continued from page 772)*

ber to speak on behalf of the association. It *must* be arranged beforehand — not by a furtive note slipped to the designated tanker half way through the address.

Would you be interested to have a series

of brief articles in the *Journal* discussing other points in the conduct of meetings, the work of committees, simplified parliamentary procedures? If so, let us know and such a series will be developed early next year.



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or Miss Kathleen Marshall, Supervisor of  
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## **WILLS EYE HOSPITAL** **Philadelphia, Penna.**

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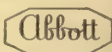


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# THE CANADIAN NURSE

## *L'Infirmière Canadienne*

A MONTHLY JOURNAL FOR THE NURSES OF CANADA  
PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION

VOLUME 52

NUMBER 10

MONTREAL, OCTOBER, 1956

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## Are we Equal to our Future?

BYRNE HOPE SANDERS, C.B.E.

A FEW HOURS AGO I stood in Jasper, Alberta. It was a still evening, with that soft afterglow which is almost unbearably beautiful. As I watched, the colors deepened on mountain peaks across which cloud shadows had raced all day. One mountain, aloof, remote, white-capped, towered into the opal sky. I heard someone beside me say "That white one is Edith Cavell."

The sentence sent my mind towards this moment when I would be standing before you. It seemed exactly right that this noble mountain should bear forever the name of that gentle nurse we all revere.

It is a deep responsibility to be the medium for carrying on the memory of another great nurse; to be the 1956 speaker for the Mary Agnes Snively Memorial. It is a responsibility which has challenged my heart and mind for some weeks.

---

Our author presented the Mary Agnes Snively Memorial Lecture on the final evening of the 28th Biennial Convention. She is Co-director, Canadian Institute of Public Opinion.

You are an inspirational audience for any speaker, in the *qualities* of your experience. You deal with the realities of life and death; with the courage and cowardice that touch us all at the most unexpected moments; with the heights of beauty to which the



(Paul Rockett)

BYRNE HOPE SANDERS

human mind can reach through suffering . . . and with the depths of selfishness to which that same suffering can sometimes bring us.

Too, you are an inspirational audience in the *range* of your experience. Some of you are young girls just starting your professional life. Some of you are mature women with a record of brilliant achievement already behind you. Some of you, I know, come from the far, lonely outposts of our land; some from the great modern hospitals that shelter a town's population within their walls.

What can I share with you that will make this evening a fitting segment in the memorial chain of addresses that honors our great Canadian nurse, Mary Agnes Snively?

I would like to turn your minds, tonight, for a little while, away from your role as nurses, as professional women — to your role as women, as Canadian women, in particular. All week you have been thinking about your professional status, your professional problems. All week you have been sharing experiences and ideas with each other, as members of the great nursing profession.

Will you think of yourselves, for a little, just as women?

Each one of us has an image of what we would like to be. One of my favorite stories is about the Great Stone Face — you surely have read it. It tells of a small boy, Ernest, who grew up in a valley deep in a range of mountains. Outlined against the sky was a Great Stone Face with a nobility and simplicity that won the heart-felt respect of everyone in the valley. Legend had it that one day a man would come home to the valley who would be the living image of that noble head. When the boy was young, a great soldier came back to his home in the Valley; and the villagers predicted that he would be the image of the Great Stone Face. But when he came — they could see he was not. Years passed, and in time a famous poet returned to the Valley. This was the one, the people felt, who would carry the image of the noble face. But as the young man looked at him, he turned away sadly; for there was no real resemblance. And, in fullness of time the boy matured and grew to be an old

man, searching always for the one who would be the Great Stone Face. When he was very old, a great Statesman came back to the Valley. "This was the one," cried the people, and hurried to see him. But Ernest turned aside, sad and old, realizing how great a contrast there was. When he died, after a lifetime in the Valley, and lay in his coffin, hands folded gently across his heart, the people came and wondered, saying "See — here — at last — here is the perfect image of the Great Stone Face!"

By searching always for the true meaning of his ideal; by thinking of its nobility, its truth and beauty, the boy came, in time, to be the expression of that ideal himself. Over us all lies the image of the great nurse whose life we honor. In each of our hearts lies the secret person-image of the woman we would like to be.

An ideal is always abstract. If you study classic Greek sculpture you will see how all detail is eliminated. Eyes are blank; faces smooth; everything subordinated to a pure beauty of abstract form. Each of us must struggle daily with an infinitude of details in our everyday life. But there are certain exercises each one of us can take to help develop that personal ideal which we would like to become.

As women, let us think of ourselves, what we are and what we may become. Let us set the image of our hope before us, as the boy in the Valley saw his ideal carved out of mountain rocks.

As Canadian women, we are half the Canadian nation. Canada is one of the few remaining nations in which the sexes are balanced, fifty-fifty. In the United Kingdom and in Europe there are far more women than men. The United States has just passed the border line of an equal division. The only trouble in Canada is that too many of the men are up in the northern wilds of the country! In many of our cities there are, right now, more women than men.

In my work with the Gallup Poll, we study constantly the five regions into which Canada is divided broadly — Maritimes; Quebec; Ontario; Prairies and British Columbia. They remind me always of the five members of a very lively family — each one different, so different that you wonder



how they can form one family but as a group united deeply in a family unit. Who among us has given any real thought to what it means to be a Canadian? As the years pass we are developing our national consciousness — and as women we are half that national consciousness. I suggest that we need to give more direct, definite thought to what our nationality means to us as individuals. Ask people to tell you "off the top of their heads" what they think of first when they think "I am a Canadian" — and you will get some strange answers. While many people will reply in terms of the Royal Family — or of the Mounties! — a great many will say things like; "The cry of a loon on a lonely lake." "The sparkle of sun on fresh snow." What is your first thought in feeling "I am a Canadian?"

As Canadian intelligences, we women have to develop our opinions on national and international matters more definitively. I used to think, during my editorial work, and my work with the Government during the war, that there was a *woman's point of view*. Research has taught me that, generally speaking, there is no such thing. Women react to ideas in much the same proportion as do men, on practically every type of question.

But there is one big difference! On many important questions one finds a far greater proportion of women than men who say "I have no opinion." It is obvious that men, in the main, have more opportunity to discuss questions of the day, than does the average housewife — but it is very evident that we women, as half the national intelligence, need to think more concretely about such issues — and to decide what our own opinions are. For it is the thinking people who guide the destinies of a nation by developing public opinions. It is the leaders who make history in a nation, a community, a profession — not the masses.

Take a little time, then, to sort out your opinions about some of the important issues of the day. But don't wear the blinkers of prejudice! Remember that everyone is right — from his own point of view! It is unwise to cling tenaciously to your own ideas without considering the other person's point of view.

I have always liked a story of Sir Wilfrid Laurier. He was preparing to present a very important bill in the House. The night before, he paced his room endlessly. His secretary appealed to him; "Sir Wilfrid, why don't you stop work and take some rest? You have all your points — they are irrefutable." Sir Wilfrid said; "That's the trouble. Until I know how they can refute my ideas, I've not completed the task."

That is so true in any type of work. By facing any critic, with the thought, "This person believes he is right in criticizing me" — you have an elasticity of mind that is extremely useful in the complicated lives we lead today. Whether you are in an administrative position, or not — exercise your mind continuously in trying to see why the person who criticizes you, or your actions, feels the way he does.

As a professional woman, you belong to the most popular profession for women in Canada. When we ask people which occupation, outside of marriage, they think offers the most for a young girl to enter — nursing leads the list far above any others, such as secretarial work or teaching. When we ask the nation which profession offers the least, the small percentage who name nursing do so, because, as you will probably surmise, they feel the work is too hard.

One of your problems, if you don't mind my suggesting it, lies in the very dedicated nature of your work. It is so easy for your world of ideas and contacts to narrow to the engrossing field of nursing and medical care. I remember going to Europe once and noticing a group of teachers travelling across on the same boat. As often happens, I ran into them in several spots through the ensuing summer weeks. They travelled as a group; stayed together in the same hotels; ate at the same tables; took the same tours. What, I wondered, did they really know of the people in those lands when they kept so closely together the whole time?

I would urge you to *join other professional associations*. It is valuable to learn of women's problems in other lines of work than your own. Quite frankly, I wish more nurses would enter community or public life. Believe

me, I know how busy you are; but believe me, too, there are not enough members of your profession serving in these capacities. Your own fine nursing association is, of course, your first and most beloved tie — but do experiment a little by joining with other groups. Fight the instinct which we all have to remain within our own line of work when we are off duty. In this matter it is, in all truth, a case of the pot calling the kettle black — for there is nothing I myself like better than to be with my sisters of the Press. I find it more pleasant to “talk shop” with my confreres than to make the effort to explore other avenues of professional or organizational life. So I know just how you feel. But obviously, it is a wiser course not to become too introverted in our professional life just as it is in our personal life.

I have always liked this definition of a friend; “One who brings you another pair of eyes.” As a woman, will you think seriously about the importance of *supporting other women*? Believe in women, help them, like them — as intelligences, as workers, as citizens. So often we tend to belittle our sex in ways we don’t realize. I always remember Ellen Fairclough, one of four women members of the Federal House, when she came to my office one day. “Byrne,” she demanded, “Will you join a crusade? When you know, or hear of a man who has been particularly brilliant — will you say, ‘He thinks just like a woman!’ or, ‘He’s got a brain like a woman!’?”

It is obviously difficult for many women to enter public life — our economic and sociological patterns being what they are. But if we cannot enter public life ourselves, let us do all in our power to encourage fine women who can do so, to take up these vitally important responsibilities.

I am not an ardent feminist. I believe that women are no better, no worse than men; no kinder; no more cruel. We are, I believe, intelligences, first of all and, as such, should work together for the mutual sharing of public responsibilities.

But, as intelligences, we must exercise our minds, just as it is necessary to exercise our muscles. If we do not use certain muscles they become inef-

fectual. The same principle applies to our thinking habits. Let us force ourselves, therefore, into new channels of thought; read biographies of men and women in completely different spheres of life. Look beyond our own life habits continuously. My mother used to tell us children “Live on the hills. Look out and away. Don’t bother with the troubles and niggardly upsets at your feet. Look out at what you would like to become — at what you would like to do . . . and work for that steadily.”

As intelligences, too, we cannot help but be aware of the spiritual values in life. I have never done any research on the subject, but I am certain that nurses, basically, would be among the most religious groups there are; not, perhaps, in outward manifestation, but in a deep inward awareness. One cannot work, as you do, with the imponderables of life without being conscious of the basic instinct for a spiritual awareness in all of us. This is, as I know you know, the secret of an inner serenity.

I have always loved the line: “The gods that we worship write their names in our faces.” Look at the people one meets in a single day and see the truth of that. I think of the faces of nuns I have known, and of old priests — gentle, compassionate, peaceful; of men and women with the laugh wrinkles about their eyes and tenderness at the corners of their mouth. And I think of others, with the grim hard lines of cynicism and bitterness etched in their faces. In thinking of this, I am reminded of other lines I loved:

No star is lost we once have seen  
We always may be what we might have  
been.

In discussing the image of our ideals, as Ernest thought of his Great Stone Face, as thousands of men and women have thought of the beauty of Edith Cavell’s mountain, I have left out many of the ideas and words we usually associate with women. But, I do want to leave three words with you which seem to me are at the heart of any ideal image we might want to foster: intelligence, courage, sensitivity.

I find them three good words to hang onto in the rough and tumble



of life which so often finds us apparently thrown. "Here's where a little courage will do the trick," I say, mentally picking myself up, brushing myself off, and hoping that no one has noticed my tumble. Again when troubles seem to crowd, I search for sensitivity to feel out the causes behind the sense of failure, or depression. And intelligence, of course! Isn't it a comfort the way our intelligence waits, brooding and watchful, to come to our

rescue when we are finished with our debauches of self-pity and sentiment?

No star is lost we once have seen.

We always may be what we might have been.

It's a stimulating and exciting adventure, this reality of being a Canadian woman in the midst of the twentieth century. Good luck to each of you, good luck to all of us.

## SOMMES-NOUS EN MESURE

### DE FAIRE FACE A L'AVENIR ?

BYRNE HOPE SANDERS, C.B.E.

**I**L Y A QUELQUES HEURES à peine j'étais à Jasper, Alberta, où j'admirais l'incomparable paysage. C'était une soirée douce et paisible . . . les derniers reflets du soleil couchant caressaient les cimes et ce spectacle était d'une grandeur impressionnante. Sous mes yeux émerveillés les lueurs dorées commencèrent à prendre un ton plus profond et les pics, où l'ombre des nuages avait dansé tout le jour, commencèrent à s'assombrir. Bien haut dans le ciel couleur d'opale un pic majestueux se détachait, lointain, solitaire, couronné de blanc rosé par les derniers reflets. Quelqu'un près de moi murmura: "Celui-là, le blanc là-bas, c'est le Mont Edith Cavell."

Ces mots me tirèrent de ma contemplation et je pensai soudain à ce moment où je serais ici, devant vous. Il me semblait tout à fait naturel que cette noble montagne porte à jamais le nom de cette infirmière distinguée que nous révérons toutes.

C'est une grande responsabilité qui m'échoit, à moi qu'on a désignée pour évoquer la mémoire d'une autre infirmière de grande classe . . . Mary Agnes Snively. C'est une responsabilité qui

a hanté mon esprit et mon coeur pendant plusieurs semaines.

Votre groupe constitue un auditoire capable d'inspirer n'importe quel conférencier . . . vu la *nature* de votre expérience. Vous qui êtes en contact avec les réalités de la vie et de la mort... avec le courage et la lâcheté qui touchent chacun de nous aux moments les plus inattendus . . . avec les sommets de la beauté que peut atteindre l'âme humaine par la voie de la souffrance . . . et avec les profondeurs de l'égoïsme où peut nous plonger cette même souffrance.

Vous êtes également un auditoire de choix vu la *variété* de votre expérience. Quelques-unes d'entre vous sont de toutes jeunes filles nouvellement lancées dans la vie professionnelle. D'autres . . . des femmes en pleine maturité avec, derrière elles déjà, un brillant passé. Et je sais que parmi vous il s'en trouve qui viennent de loin, des vastes solitudes de notre pays . . . alors que d'autres sont venues de nos grands hôpitaux modernes dont les murs abritent la population d'une ville.

Quel message puis-je vous apporter pour faire de cette soirée un anneau qui s'adapte harmonieusement à la chaîne des conférences qui ont été instituées pour commémorer la mémoire de notre grande infirmière canadienne, Mary Agnes Snively?

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L'auteur a donné la Conférence à la mémoire de Mary Agnes Snively, le dernier soir du 28ième Congrès biennal.

Mlle Sanders est Co-directrice de l'Institut Canadien de l'Opinion Publique.



Ce soir, je voudrais détourner pour un moment vos esprits de votre rôle d'infirmières, de votre rôle de femmes professionnelles . . . pour considérer votre rôle en tant que femmes, en tant que femmes canadiennes particulièrement. Toute la semaine, vous avez été préoccupées de votre statut professionnel, de vos problèmes professionnels. Toute la semaine, vous avez échangé des idées, des expériences, en votre qualité de membres de la noble profession d'infirmières.

Voulez-vous oublier tout cela pour penser un tout petit peu à votre qualité de femmes, de *femmes* tout court?

Chacune d'entre nous se fait une image de ce qu'elle voudrait être. L'une de mes histoires préférées est celle de la Grande Figure de Pierre . . . vous l'avez certainement lue quelque part. Elle raconte l'histoire d'un petit garçon, Ernest, qui habitait dans une vallée entourée de hautes montagnes. La nature avait sculpté sur l'une de ces montagnes une Grande Figure de Pierre qui se détachait sur le ciel et dont la noblesse et la simplicité inspiraient le plus grand respect aux habitants de la vallée. La légende disait qu'un jour un homme viendrait dans la vallée qui serait l'image vivante de cette noble tête. Le petit garçon était encore tout jeune lorsqu'un grand soldat revint à son foyer dans la vallée. Les villageois avaient prédit que ce serait lui, l'image de la Grande Figure de Pierre. Mais lorsqu'il parut, ils s'aperçurent que ce n'était pas lui. Les années passèrent . . . puis un beau jour, un poète célèbre revint dans son village. "Ce sera lui, dirent les gens, qui aura les traits de la noble figure." Mais le jeune Ernest le regarda et se détourna tristement . . . car il n'y avait aucune ressemblance. Et le jeune homme parvint à l'âge mûr puis à la vieillesse . . . cherchant toujours sur les visages les traits de la Grande Figure de Pierre. Quant il fut devenu très vieux, un grand homme d'état revint à son village natal. "C'est lui," crièrent les gens et ils se précipitèrent pour l'accueillir. Mais Ernest se détourna encore en constatant combien le contraste était grand. Quand il mourut, après avoir passé toute sa vie dans la vallée, et qu'on le déposa dans sa tombe les mains croisées doucement sur sa poitrine, les gens le contemplèrent avec

étonnement en murmurant: "Voyez . . . la voilà . . . enfin . . . l'image parfaite de la Grande Figure de Pierre."

A force de chercher sans cesse la véritable expression de son idéal . . . à force de se pénétrer de sa noblesse, de sa vérité et de sa beauté, le petit garçon était devenu lui-même l'expression de cet idéal.

Au-dessus de nous toutes plane l'image de cette grande infirmière dont nous honorons la mémoire. Dans le plus profond de nos cœurs est enfermée l'image secrète de la femme que nous voudrions être.

Un idéal est toujours abstrait. Si vous vous arrêtez pour étudier la sculpture grecque classique vous constaterez combien les détails sont simplifiés. Les yeux sont vides . . . les visages polis . . . tout est subordonné à la beauté pure de la forme abstraite. Chacune d'entre nous se débat chaque jour avec une infinité de détails. Mais il y a certains exercices que chacune peut faire pour développer cet idéal personnel que nous visons toutes.

En tant que femmes, pensons à nous-mêmes, à ce que nous sommes et à ce que nous pourrions devenir. Fixons dans notre esprit l'image de nos rêves comme le petit garçon dans la vallée qui voyait son idéal sculpté à même le roc de la montagne.

En tant que femmes canadiennes, nous représentons la moitié de la nation canadienne. Le Canada est l'une des dernières nations où les sexes sont équilibrés, moitié-moitié. Dans le Royaume Uni et en Europe, on compte beaucoup plus de femmes que d'hommes. Les Etats-Unis viennent tout juste de dépasser la ligne d'égalité. La seule chose dont nous avons à nous plaindre, ici, au Canada, c'est que trop de nos hommes sont dans les régions désolées du grand nord! Dans un grand nombre de nos villes, à l'heure actuelle, il y a plus de femmes que d'hommes.

Dans mon travail à l'Institut Canadien de l'Opinion Publique, nous étudions constamment les cinq grandes régions qui forment le Canada, soit les Maritimes, Québec, Ontario, les Prairies et la Colombie-Britannique. Ces régions ne font toujours penser à cinq membres d'une même famille, une famille pleine de contrastes . . . chacun avec une personnalité différente, tellement différente qu'on se demande

comment ils peuvent être de la même famille . . . mais comme groupe ils sont profondément unis et forment une cellule familiale harmonieuse. Laquelle d'entre nous s'est jamais demandé sérieusement ce que cela veut dire, être Canadienne? Au fur et à mesure que passent les années notre conscience nationale se développe . . . et comme femmes, nous sommes la moitié de cette conscience nationale. Je suis d'avis qu'il nous faut songer de façon plus concrète, plus positive, à notre nationalité et à ce qu'elle signifie pour nous en tant qu'individus. Demandez aux gens de vous dire spontanément ce qui leur vient à l'idée lorsqu'ils pensent "Je suis Canadien" . . . vous aurez des réponses bien étranges. Beaucoup de gens répondront en brochant sur la Famille Royale — ou sur la "Police Montée"! Plusieurs vous diront des choses comme ceci: "Le cri du canard sauvage sur un lac solitaire" ou encore "Le scintillement du soleil sur la neige fraîche." Et vous, qu'est-ce qui vous vient à l'esprit lorsque vous songez "Je suis Canadienne?"

Comme membres intelligents de la famille canadienne il importe que nous, les femmes, nous efforcions de développer de façon plus définie nos opinions sur les affaires nationales et internationales. Au cours de mon travail de journalisme et lors de mon stage auprès du Gouvernement pendant la guerre, je m'étais fait l'idée qu'il existait un *point de vue féminin*. Mon travail de recherche par la suite m'a appris que, de façon générale, il n'existe pas de telle chose qu'une opinion féminine. Sur presque chaque genre de question les femmes réagissent aux idées à peu près dans la même proportion que les hommes. Mais il y a tout de même une grande différence! Sur un grand nombre de questions importantes on constate qu'un pourcentage beaucoup plus considérable de femmes répondent: "Je n'ai pas d'opinion." Il est vrai que l'homme, en général, a plus d'occasions que la ménagère moyenne de discuter des problèmes du jour . . . mais il est évident que nous, les femmes, qui représentons 50 pour cent de l'intelligence de la nation, devons réfléchir de façon plus concrète à ces problèmes et nous former une opinion. N'oublions pas que ce sont les gens qui réfléchissent qui guident les destinées d'une nation en

orientant l'opinion publique. Ce sont les personnalités dirigeantes qui façonnent l'histoire d'une nation, d'une communauté, d'une profession — et non pas la masse.

Alors arrêtons-nous donc un moment pour débrouiller nos opinions concernant les problèmes importants de l'heure. Mais gare aux préjugés! Souvenez-vous que chacun a raison . . . à son point de vue! Il n'est pas sage de vous accrocher obstinément à vos propres idées en négligeant de considérer le point de vue de l'autre personne.

J'ai toujours eu un faible pour une anecdote se rapportant à Sir Wilfrid Laurier. L'homme d'état travaillait à un mémoire important devant être soumis à la Chambre. La veille de la séance, il se mit à arpenter sa chambre et n'en finissait plus de marcher de long en large. Finalement son secrétaire, n'y tenant plus, le supplia: "Sir Wilfrid, pourquoi ne pas vous arrêter et prendre un peu de repos? Vous avez tous vos arguments en blanc et noir . . . il sont irréfutables." Sir Wilfrid répondit: "Je n'aurai pas fini ma tâche tant que je n'aurai pas prévu *leurs* arguments pour réfuter les miens."

Et ceci est vrai dans tous les domaines. Si vous faites face à la critique en songeant "Cette personne est convaincue qu'elle a raison en me critiquant," vous avez déjà atteint une souplesse d'esprit extrêmement utile dans la vie compliquée que nous menons de nos jours. Que vous soyez dans l'administration ou non, entraînez constamment votre esprit en essayant de comprendre les mobiles qui portent telle personne à vous critiquer ou à critiquer votre manière d'agir.

Comme femmes professionnelles, vous appartenez à la profession féminine la plus populaire au Canada. Quand nous demandons aux gens quelle occupation, en dehors du mariage, ils estiment offrir le plus d'avantages pour une jeune fille, le nursing est à la tête de toutes les autres y compris l'enseignement et le secrétariat. Quand nous sondons la population du pays pour savoir quelle occupation, à son avis, est la moins attrayante, le pourcentage minime qui se prononce pour le nursing estime — vous l'aurez sans doute deviné — que les infirmières



res travaillent trop fort.

L'un de vos problèmes — si vous me permettez de le signaler — réside dans la nature même de votre travail qui accapare toute votre énergie et toutes les ressources de votre cœur et de votre esprit. Il est si facile pour vous de rétrécir votre horizon en le bornant au champ d'action qui vous est propre et qui vous absorbe entièrement. Je me souviens avoir remarqué, au cours d'un voyage en Europe, un groupe d'institutrices faisant la traversée sur le même bateau. Comme il arrive souvent, je les rencontrai à plusieurs reprises sur le Continent au cours des semaines suivantes. Elles voyageaient en groupe, logeaient aux mêmes hôtels, mangeaient à la même table, faisaient les mêmes excursions. Et je me demandais : "Qu'est-ce qu'elles peuvent bien apprendre des habitants des pays qu'elles visitent en se tenant toujours ensemble comme des couventines?"

Je vous recommande de vous joindre à d'autres associations professionnelles. C'est un avantage précieux que de connaître les problèmes qui confrontent les femmes dans d'autres champs d'activités que le vôtre. Je vous avoue franchement que, pour ma part, je voudrais voir un plus grand nombre d'infirmières participer à la vie publique ou aux activités civiques. Je me rends compte — croyez-le bien — à quel point vous êtes occupées; d'autre part, croyez-moi lorsque je vous dis qu'il n'y a pas assez d'infirmières qui s'adonnent à ces activités. Bien entendu, votre propre association d'infirmières constitue votre principal lien et celui qui vous tient le plus à cœur, mais tentez une petite incursion dans les autres groupes. Lutte contre cet instinct que nous avons toutes de nous confiner à notre propre "espèce" en dehors des heures de travail. En toute franchise, il s'agit ici de l'attraction naturelle qui nous pousse à fréquenter nos "consoeurs" — par exemple, en ce qui me concerne, rien ne me plaît davantage que de rencontrer mes camarades de la Presse. Je trouve plus agréable de "parler métier" avec mes confrères que faire un effort pour explorer d'autres domaines de la vie professionnelle ou publique. Je suis donc en mesure de vous comprendre. Mais de toute évidence, il est plus sage de

ne pas être trop introvertie dans notre vie professionnelle, pas plus d'ailleurs que dans notre vie privée.

J'ai toujours apprécié cette définition d'une amie "Une personne qui vous apporte une autre paire d'yeux". Puis-je vous suggérer de réfléchir sérieusement, en votre qualité de femmes, à l'importance de *soutenir les autres femmes*? Faites confiance aux femmes, appréciez-les en tant qu'intelligences, en tant que travailleuses, en tant que citoyennes. Nous sommes si souvent portées à déprécier notre sexe sans nous en rendre compte. Je me souviendrai toujours du jour où Ellen Fairclough, l'une des quatre femmes membres du Parlement, entra dans mon bureau : "Byrne, me dit-elle, veux-tu entrer en croisade?" Quand vous connaissez ou que vous entendez parler d'un homme particulièrement brillant, direz-vous : "Il pense tout à fait comme une femme" ou bien "Il est aussi intelligent qu'une femme?"

Il est entendu que pour un grand nombre de femmes il est difficile de se lancer dans la vie publique, considérant notre statut économique et social. Mais si nous ne pouvons participer nous-mêmes activement à la vie publique, faisons tout en notre pouvoir pour encourager les femmes douées qui peuvent s'y consacrer et qui sont capables d'assumer ces responsabilités essentiellement importantes.

Je ne suis pas une féministe ardente. J'estime que les femmes ne sont ni meilleures ni pires que les hommes — ni plus humaines, ni plus cruelles. Je crois qu'avant tout nous sommes des êtres intelligents et que, comme tels, nous devrions unir nos efforts pour partager mutuellement les responsabilités publiques.

Cependant, comme êtres intelligents, il nous faut exercer nos esprits autant que nos muscles. Si nous ne nous servons pas de certains muscles ils s'atrophient. Le même principe s'applique à nos habitudes de réflexion. Faisons-nous donc violence pour explorer de nouveaux horizons—lisons des biographies d'hommes et de femmes dans des sphères d'activités complètement différentes. Portons nos regards et nos pensées au delà de nos propres routines de vie. Ma mère nous disait souvent lorsque nous étions enfants : "Restez sur les hauteurs. Regardez au loin



et plus haut. Ne vous arrêtez pas à scruter les bouleversements et les tracasseries qui sont à vos pieds. Visez haut et songez à ce que vous voudriez devenir . . . à ce que vous voudriez accomplir . . . et travaillez sans relâche pour y parvenir."

En tant qu'êtres intelligents on ne peut pas non plus s'empêcher d'être conscientes des valeurs spirituelles de la vie. Je n'ai jamais fait de recherches sur le sujet, mais je suis convaincue que les infirmières sont, fondamentalement, parmi les groupes dont les convictions religieuses sont le plus fermes; peut-être pas en manifestations extérieures mais dans la profondeur de leur âme. On ne peut pas être en contact avec les impondérables de la vie, comme vous l'êtes, sans avoir conscience de l'instinct qui anime chacun de nous sur le plan spirituel. Et vous le savez aussi bien que moi, c'est là le secret de la sérénité intérieure.

J'ai toujours aimé ce verset: "Le Dieu que nous adorons imprime son nom sur nos traits." Regardez les gens que vous rencontrez au cours d'une journée et constatez cette vérité. Je songe aux visages de certaines religieuses que j'ai connues et à ceux de certains vieux prêtres . . . empreints de bonté, de compassion, de sérénité. Je songe aux hommes et aux femmes dont le rire a creusé des sillons aux coins des yeux et dont la bouche souriante exprime la tendresse. Et je pense aux autres dont les traits portent l'empreinte du cynisme et de l'amertume. Ces réflexions me rappellent un autre vers que j'affectionne particulièrement:

L'étoile qu'on a vue briller  
ne s'éteindra jamais

On peut toujours devenir  
ce qu'on aurait pu être.

Au cours de ma dissertation sur notre idéal alors que j'ai évoqué Ernest et la Grande Figure de Pierre et que j'ai rappelé les milliers d'hommes et de femmes qui ont admiré le Mont Edith Cavell, j'ai laissé de côté un grand nombre des pensées et des mots que l'on associe d'habitude avec les femmes. Cependant, je voudrais vous laisser trois mots qui me semblent être à la base de tout idéal: intelligence, courage, sensibilité.

J'estime que ces trois mots sont tout indiqués pour nous soutenir dans les combats de la vie qui semblent parfois nous désarmer. Je me dis souvent: "C'est ici qu'il me faut du courage" et je me redresse, je me secoue, espérant que personne n'a remarqué ma défaillance. Et quand les difficultés m'étreignent de nouveau je fais appel à ma faculté de sentir pour tâcher de découvrir la cause de ce sentiment de défaite, de cette dépression qui m'enserre. Et je n'oublie pas cette faculté qu'est l'intelligence! N'est-ce pas un réconfort de sentir qu'elle est là en attente, qui médite et qui veille, prête à bondir pour nous secourir lorsque, enfin, on a fini de s'apitoyer sur soi-même et de flirter avec la sensiblerie?

L'étoile qu'on a vue briller  
ne s'éteindra jamais  
On peut toujours devenir  
ce qu'on aurait pu être.

C'est une aventure excitante et stimulante que d'être une femme canadienne en plein vingtième siècle. Bonne chance à chacune de vous! Bonne chance à nous toutes!

The use of fiberglass may soon provide radical changes in setting fractures and making artificial limbs for amputees. One hospital has reported its use in the preparation of body casts where it was found to be lighter and stronger than plaster and gave a faster recovery. Meanwhile a man who had undergone double amputation successfully lined his artificial limbs with fiberglass matting and molded an artificial limb of the new material for a 12-year-old boy. A fiber-

glass body cast is estimated to be 7 pounds lighter than its plaster counterpart. It has the added advantages of being adjustable if the patient loses or gains weight; can be removed, cleaned and reapplied. The artificial limb is about 5 pounds lighter than wood. It is felt that the contours of the natural limb can be much more closely duplicated when fiberglass is used — an important factor in production of artificial limbs for women.

# Signpost at Geneva

DOROTHY M. PERCY

IN AN UNGUARDED MOMENT, and when the Biennial still seemed comfortably far off, I promised to take part in the program by speaking on the sufficiently vague topic: "Trends in Health Services." I have since changed the title of my remarks to: "Signpost at Geneva." For this I offer no apology. In the circumstances it seemed imperative that a change of title and content be made.

It has been said by someone whose name I have long since forgotten, doubtless a public relations expert, that "news, like fish, should be fresh." I suspect that in one way or another many here today have already been exposed to the first repercussions of the Technical Discussions on Nursing which took place at the Ninth General Assembly of the World Health Organization in Geneva. To them what I have to say will not, therefore, in the strict sense of the word, be news.

However, I am under compulsion (self-imposed, perhaps, but nonetheless valid) to bring to the membership at large some word of the proceedings of that meeting. I take very seriously this matter of reporting back to the Canadian Nurses' Association. I am fully

aware that it was due, in no small measure, to the strong representations made to my Minister by the CNA that the rare privilege was accorded me of accompanying the Canadian delegation and participating in the Technical Discussions. At this time I want to record my sincere appreciation of this generous gesture.

To understand the significance of the intense activity that centred around the Technical Discussions, it is necessary to give some background information.

It has been the custom at each General Assembly of W.H.O. to have what are known as "Technical Discussions," running concurrently with the General Assembly itself. Each year the topic is different. Last year when the Eighth General Assembly met in Mexico City the topic chosen was "Rural Health Units."

Two years ago "Nursing" was proposed as the topic for the Discussions of 1956. Between 1954 and 1956 an immense amount of careful detailed planning went into the preparation for the sessions.

This year, for the first time, the Technical Discussions were scheduled on days when there were no other main meetings. Partly for this reason and, partly too I like to think, because of the intrinsic interest of the subject, the opening and closing sessions of the Technical Discussions were extremely well attended by official delegates of the various countries.

This year's Technical Discussions chalked up another "first" — chairmanship by a woman. Dame Elizabeth Cockayne, Chief Nursing Officer of the Ministry of Health for England



*John Steele*

DOROTHY M. PERCY

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and Wales, was nominated by the President of the Assembly for this post and appointed to it by the Executive Board of W.H.O.

The theme selected for the Technical Discussions — "Nurses — Their Education and Their Role in Health Programs" was submitted for study in 1955 to member countries of W.H.O.; to national associations of the International Council of Nurses; to the International Committee of Catholic Nurses and Medical Social Workers and to the national societies of the League of Red Cross Societies.

Reports were received by W.H.O. from 40 countries. These Reports had been skillfully compiled into one comprehensive Study Document, for use in the group sessions, by Miss Pearl McIver, Chief Nurse, U.S. Public Health Service, who had been seconded for several months to W.H.O. as special consultant to do this difficult and exacting job. Tribute was paid to Miss McIver on several occasions, and the timely announcement on the last morning of a special Public Health Nursing award to Miss McIver by the American Nurses' Association, then meeting in biennial session in Chicago, was well received.

Nurses accompanied official delegations from 21 countries this year. This in itself was significant, although perhaps not entirely satisfactory when one considers there are 88 member countries in the World Health Organization.

It is, perhaps, also of interest to note that those participating in the Technical Discussions did so as individuals and not as official representatives of their countries. This, of course, made for greater informality and freedom of expression.

The Reports sent in from the various countries were available in the W.H.O. Library. They made interesting reading. They were not at all stereotyped, and although many common problems were highlighted, the analysis of these problems and the suggested solutions showed considerable variation and individuality of approach. They revealed, too, the vastly differing levels of nursing development as between countries. Reading them, one could be forgiven a temporary mood of slight despair that at a few brief discussion sessions

anything remotely resembling common ground could be reached. In this happily, I was mistaken. Incidentally, I heard it said by those whose opinion I value, that the Canadian Report was one of the best.

A final statistic or two before attempting to convey to you something of the feel of the sessions. Eleven hours were devoted to the Technical Discussions. In this time there were two plenary sessions — opening and closing — and three sessions each of nine discussion groups. Total registration was 213. Each of the discussion groups had an average attendance of 20. More than 200 persons attended each of the plenary sessions.

Not only was there careful preplanning for these sessions, but at the time of the actual discussions the whole resources of the World Health Organization (and I speak with unabashed awe in my voice when I say that) were placed at the disposal of the participants. These resources included the miracle of simultaneous translation. This service always impresses me tremendously and is, I feel, the amalgam that first brings together, then keeps together ideas which, in such a real sense, are the very stuff of life. The interpreters are very skilled at their job. The whole three weeks of each General Assembly every year must be something of an endurance contest for them, but nothing suggesting a bored, cynical or mechanical attitude to duty is permitted to come through the earphones. There, not only the actual words of each speaker but his nuances and shades of emphasis are faithfully given. "Artistic" is one word which occurs to me to describe the work of this essential group.

Another marvel at Geneva is the calibre of the clerical and stenographic staff. I don't know how the system works. I do know it is extremely efficient. By 6:30 each morning throughout the entire three weeks of the General Assembly each delegate received a complete set of minutes and reports of the preceding day's business, together with the current agenda.

With this tangible, practical support in the background, and also due, I should think, in large measure to the not inconsiderable powers of concentration exhibited by Dame Elizabeth



and Miss McIver, the Final Report of the Technical Discussions, as a whole, and the summary of proceedings in the nine groups were available on the Tuesday morning following the actual sessions of Friday and Saturday of the preceding week. Of course, the Rapporteurs did a little work, too!

So, the stage was set for the opening plenary session at 9:00 o'clock on Friday morning May 11th. It was held, not in the very large and dignified Assembly Hall with its five bronze doors, its murals, its thick blue carpeting, its almost perfect acoustics, but in another hall also large and well adapted to its purpose — ordinarily the scene of the work of the Budget and Program Committee of the Assembly.

There is no doubt that all those present felt this to be an historic occasion, marking as it did the first time that nurses, doctors and health administrators, on a world scale, had sat down together to consider some facets of the complex problems of nursing.

Dame Elizabeth Cockayne, in her opening remarks, reminded her audience on this, the eve of Florence Nightingale's birthday, that although Miss Nightingale herself wrote many thousands of words, she had little patience with words without action. Nurses are anticipating action in their plans to improve nursing service and to provide better educational facilities for professional nurses. Dame Elizabeth emphasized the need to limit the discussions to the role and the education of professional nurses because of the limited time available. Therefore, the activity of auxiliary nursing personnel would be considered only in relation to the role and responsibilities of professional nurses.

Dame Elizabeth then introduced the four symposium speakers whose papers set the theme for group discussions:

1. "An Account of the Preparations made in India for the Technical Discussions" by Miss Adranvala, Chief Nursing Superintendent, India.
2. "The Health Administrator Views the Role of the Nurse in the Health Program" by Dr. Allwood-Paredes, Director-General of Health, El Salvador.
3. "The Implications of this Role for

Nursing Service and Nursing Education" by Miss Duvillard, Director, Bon Secours School of Nursing, Geneva.

4. "The Contribution of the Doctor and the Health Administrator in the Future Development of Nursing" by Professor Canaperia, Director, International Health Service, Italy.

There is a temptation, which must be resisted, to quote briefly from each of these papers. There is not time to do this and such random sampling would not do justice either to the authors or to their papers. I would hope that these papers would eventually be made available to everyone. Each has its own excellencies, and the whole session, admirably summed up by Miss McIver, served as a springboard for the discussion groups that followed immediately.

The real work of the Technical Discussions was, of course, done in the groups. Registrants had been assigned to groups on the basis of language choice to provide a fair distribution according to geographic areas and fields of work. A member of the Secretariat of W.H.O. was assigned to each group to assist the chairman and to facilitate arrangements. Each group selected its own Rapporteur and each group was free to choose any or all of the suggested questions contained in the background paper for discussion, or other problems if they so desired.

The three Canadians were kept quite busy: Dr. Roth, Deputy Minister of Health for Saskatchewan, and I were detailed as Rapporteurs for our respective groups which meant quite a lot of homework over the weekend to meet deadlines.

#### THE ROLE OF THE NURSE IN HEALTH PROGRAMS

All the groups reviewed the functions in the background paper and there was general agreement that the role of the nurse will vary according to the availability of all types of health personnel, the particular health problems of the area, the stage of development of the health programs of the country, and the level of both general and professional educational achievement within each country. The specific functions which are performed by nurses in some countries may be inappropriate or impossible in other countries at

this time. Therefore, it appears necessary for each of the countries to analyze its own situations and to prepare specific statements which are in accord with conditions as they are at present in those countries. For example, there is a tendency in some countries for nurses to perform some of the technical functions formerly considered to be medical functions. Some of the groups believed that these functions were medical responsibilities and should not be delegated to nurses. Some of the groups suggested that such assignments were what prevented nurses from *nursing* which is their first professional responsibility. In other countries where nurses have been thoroughly instructed in performing these techniques (such as intravenous injections) physicians prefer to assign those functions to nurses, and if there are enough nurses to carry both nursing and technical functions of this type, this may be a very acceptable arrangement.

However, there was general agreement that certain broad basic responsibilities should be included in the role of the nurse in every country and if not included in her current role, they could be included as goals to be attained in the near future. *Five* functions are listed as being essential responsibilities of professional nursing:

1. Giving skilled nursing care to the sick and disabled in accordance with the physical, emotional and spiritual needs of the patient whether that care is given in hospitals, homes, schools or industries.

2. Serving as a health teacher or counsellor to patients and families in their homes, in hospitals or sanatoria, in schools or industries. Because of her extensive and intimate contact with patients and families, the nurse usually has the confidence of the family and is in a strategic position to put scientific information into simple language which they will understand, accept and put into practice.

3. Making accurate observations of physical and emotional situations and conditions which have a significant bearing on the health problem and communicating those observations to other members of the health team, or to other agencies having responsibility for that particular situation. Thus the nurse is a very valuable liaison between the patient and the physician, the research scientist, the sanitarian, the social worker, the school teacher or the industrial foreman.

4. Selecting, training and giving guid-

ance to auxiliary personnel who are required to fulfil the nursing service needs of hospital or public health agency. This also involves an evaluation of the nursing needs of a particular patient and assigning personnel in accordance with the needs of that patient at a particular time.

5. Participating with other members of the team in analyzing the health needs, determining the services needed, and in planning the construction of facilities and the equipment needed to carry out those services effectively.

## THE EDUCATION OF THE NURSE

Each of the nine groups devoted considerable time to this phase of the subject. While each group approached it somewhat differently, the conclusions reached were amazingly similar.

*Recruitment of students:* It was agreed by all the groups that attracting a sufficient number of qualified candidates for schools of nursing and selecting the most suitable ones, is a big problem. Several suggestions were made by the various groups which may aid or influence the recruitment of student nurses:

1. The attitude of the public towards the nursing profession influences recruitment of students more than any single factor. (Physicians can and have been influential in creating a good opinion of nursing).

2. Comfortable living quarters for students which provide them with an opportunity to lead a normal life.

3. Accurate and attractive information about the activities of and the opportunities for nurses should be conveyed to parents of potential candidates, and to teachers and students in secondary and preparatory schools. Several groups expressed a need for films, other visual aids and pamphlets in the language of the country.

4. While a good general education is an important requirement, personal characteristics such as an interest in people, a desire to serve mankind, and an ability to understand and accept people are important qualities in a nursing candidate.

5. Some countries have found that those nursing schools which provide a high standard of education attract and retain more and better qualified students. Though educational requirements are



very important, one group emphasized that a beginning must be made with the available resources. It was realized that all countries might accept this standard as their aim even though it might have to be reached through successive stages of development.

6. Bursaries or stipends should be provided for those students unable to pay for their education in nursing.

*Organization and administration of basic schools of nursing:* All the groups agreed that the primary purpose of a school of nursing was to provide a sound education in nursing. It was recognized that some nursing schools appear to be organized primarily to provide service to the patients of a particular hospital. Student nurses do and should render nursing care to patients. However, the nursing service assignments of students should be based on the educational needs of the student rather than on the needs of the hospital. Therefore, the majority of the groups advocated that schools of nursing be administered as separate entities and, where possible, as an integral part of a university or other educational institution.

The schools of nursing should be directed by a qualified nurse who is skilled in teaching and familiar with methods of educational administration. Physicians who are skilled teachers are also required. For this reason, as one delegate suggested, the establishment of a nursing school in a medical centre which supports a medical school also is desirable. Since the practical or clinical education of the nurse is fully as important as the theoretical instruction, all nurses who serve as nursing supervisors in the clinical areas need to be interested in education and skilled in teaching. It was agreed by all that the nurse teacher must be a competent nurse who has had post-basic preparation in teaching.

A good nursing school, as any other type of professional school, requires financial support in addition to the tuition or fees paid by students. A nursing school should not be expected to operate on funds contributed by the hospital in payment for student services. Financial support from the government or from private sources should be provided for nursing schools in the same manner as it is provided for other types of professional schools.

The budget should be adequate to provide the necessary library facilities, textbooks, teaching and laboratory equipment as well as salaries for the teaching and adminis-

trative staff. Scholarships, bursaries or stipends may be required for those students who need financial assistance. Funds for the construction and maintenance of residence halls for both students and teaching staff should be provided unless other provisions are made for the necessary living and recreational facilities.

The curriculum of the school of nursing should provide for a general education in nursing, including instruction and experience in surgical, medical, pediatric and maternity nursing. In addition, all the groups urged that more emphasis be given to preventive medicine and the promotion of health. It was agreed that experience in health centres and homes (under the supervision of public health nurses) should be included also. Recognition of the need for such background subjects as sociology and psychology was emphasized as was the need to teach and practice sound principles of mental hygiene and human relationships throughout the entire curriculum. Guidance and character building activities should be encouraged to assure the development of emotionally secure and socially acceptable young people. Modern methods of instruction such as seminar discussions, demonstrations and ward clinics should be employed as well as formal lectures.

It was pointed out that in some countries where midwifery training has been well established, nursing schools give little or no preparation in maternity nursing. Maternity nursing was believed to be an essential part of the nursing school curriculum, although the basic school should not be expected to prepare its graduates for midwifery practices.

One of the groups called attention to the preponderance of men among the nurses in some countries. It was agreed that men nursing students should be given the same instruction and experience as that required of women students.

*Post-basic education:* The groups agreed that teachers, supervisors, and administrators in both hospital and public health nursing services, needed additional preparation beyond that received in the basic nursing schools. Some countries have established post-basic programs of study in these fields and also in some clinical specialities. It was agreed that it is desirable that post-basic courses should be on a university level and, where possible, under university direction.

In those countries where this type of post-basic education is not available, scholarships should be provided for study outside



the country. Even when some facilities are available within the country, selected nurses with experience and maturity will benefit greatly by study abroad. Scholarships or bursaries should be available for such study.

Even the best qualified person must be learning continually if he is to keep up-to-date with scientific discovery and progress in the health sciences. Therefore, refresher courses, seminars and conferences for supervisors and teachers need to be provided. Some of these may be held jointly with other professions represented on the health team. Others may be arranged for a specific group, such as public health nurses, hospital nursing supervisors, nursing teachers for a group from several neighboring countries on a regional basis. Funds should be provided for the support of this type of refresher work.

### THE ADMINISTRATION AND EFFECTIVE UTILIZATION OF NURSING SERVICES

While the background paper considered "utilization" and "administration" as separate subjects, the group chairman and rapporteurs agreed that effective utilization was one phase of good administration. Therefore, in presenting the summary of the group discussions, these two aspects were combined.

All the groups emphasized the importance of "the health team" and the value of a good team spirit. It was agreed that there are various types of teams within the hospital or public health agency. There is the administrative team made up of the medical officer and the chiefs of all divisions or departments. There are teams which may be planning and promoting a special health program such as malaria control or child hygiene. There are nursing teams on each ward or unit of a hospital or teams concerned with rehabilitation of chronic disease patients which may be composed of physician, nurse, physical therapist, occupational therapist, psychologist, etc. The hierarchy of health and hospital administration tends to make the development of the team spirit difficult — but this can be overcome by an attitude of respect for the dignity of the individual in whatever capacity he (or she) may be serving. This team spirit, which involves a mutual recognition of the responsibilities and capabilities of each member of the team, can be developed through a sharing of suitable learning experience with various members of the health professions in staff meetings, conferences and

seminars and in joint participation in solving a problem which is of concern to the whole staff.

It was suggested that this interchange of knowledge about the functions of other members of the health team and experience in working as a team member should begin early — preferably while they are students in medical, nursing, or other professional schools. More emphasis on the principles of mental health, human relations, and sociology in the basic education of all members of the health team will prove beneficial, provided the faculty and other personnel of the educational institution also practise these principles of good interpersonal relationship. The medical officer is usually, though not always, the leader of a health team. Whoever is the leader must be able to inspire his teammates to work *with* him, not *for* him.

The organization of the agency administering the health services was considered briefly in several groups. Hospital or public health services are usually under the direction of a physician who is responsible for the entire health service of the agency. Even in the smallest administrative unit of the hospital or public health agency there will be one or more of several types of workers such as nurses, sanitarians, dietitians, auxiliary workers, etc. In most countries, nurses comprise the largest number of health personnel in either a hospital or a public health service.

The selection of a competent chief nurse to serve as the leader of the nursing team is considered essential. The chief nurse will be responsible to the director of the total health service for the amount and quality of nursing service required to carry out the entire health program. In this capacity (as chief of the nursing service) she would be a member of the administrative team of which the physician in charge is the team leader, and would participate on the policy level in analyzing the health service needs, in planning how best to meet those needs, and in suggesting ways by which the total service may be improved.

A similar pattern of organization on the state, provincial and national level is considered essential for effective administration. A majority of the discussion groups emphasized the need for a chief nursing officer in the national or federal health agency. This nurse should be directly responsible to the administrator of the health program for that country and some of the usual functions of such a nurse are:

1. Participating in planning the national health program;

2. Acting in an advisory capacity and as an interpreter of nursing trends to her own department and to other departments of government on matters relating to nursing;

3. Giving leadership in all areas of nursing, in particular assisting with the improvement of standards of nursing education and nursing service.

In countries where the accreditation of nursing schools and the licensing of nursing practitioners is a responsibility of the Ministry of Health, these functions would also be under the general supervision of the chief nursing officer.

The primary purpose of legislation concerning the practice of nursing is to protect the public from unqualified practitioners and ensure a high quality of nursing service. Several groups stressed that the laws should grant broad authority to the licensing body but that too many details should not be written into the law. Authority to prepare regulations regarding the details should be included but the regulations themselves should be flexible enough to permit approval of experimental types of nursing schools, granting of licences to graduates of accredited nursing schools in other countries and otherwise encourage the development of standards higher than the minimum requirements.

Several groups mentioned the importance of consulting the national nursing organization of the country before introducing any legislation. Not only will the nursing organization have many helpful suggestions to offer, but it can be a strong support in securing passage of the act.

Effective utilization of all available nursing resources is a very important aspect of good administration. Several of the groups emphasized the importance of doing job analyses to ascertain the functions of all members of the health team in order that the members understand fully not only their own functions and responsibilities but those of their co-workers. The scientific information derived from such studies will not only make it possible to plan for a better utilization of the services of each worker, but may also justify spending more money for additional equipment which, by saving nursing time, will result in more and improved services, thereby saving money in the end.

It was felt that each institution or agency should study its own problems in order to enable the nurse to work efficiently.

Examples cited were: giving attention to the location of service rooms and the arrangement of equipment when the hospital or health centre is constructed; grouping patients according to the severity of their illness; providing facilities for ambulatory patients to eat their meals in a dining room instead of serving them in their ward; providing "recovery rooms" for postoperative patients so that emergency facilities and equipment may be available immediately with the minimum of time and effort.

Job analyses and studies of this type help the nurses to view their own jobs objectively and will help them to revise some of the traditional methods which have been rigidly carried out simply because that was the pattern which existed when they were students.

A careful analysis may show how the services of married nurses may be used who, because of family responsibilities, cannot engage in full-time nursing work. It may also show where men nurses can serve more effectively than they are presently permitted to do in some countries.

A point of warning was brought out by one group. Efficiency experts should be guided by a committee of physicians and nurses or they may not see the significance of certain professional details. It was also believed that the results of the studies required professional interpretation.

It is generally agreed that productive work is possible only when the workers gain personal and professional satisfaction from their employment. Assurance that their working and living environment offers a standard of comfort and convenience comparable to that enjoyed by other professional workers in the area is important. Therefore, administration must be concerned with the establishment of good personnel policies — hours of work, salaries, promotion policies, vacation periods, sick leave and retirement pensions. Provisions must also be made for adequate work space, the required clerical assistance and sufficient supplies and equipment to permit effective functioning.

With regard to living conditions, one of the participants said it was "essential for nurses to lead a private life, similar to that of other members of the community." This means that hospital nurses should have a choice as to living in an apartment or flat in the community or in a hostel in connection with the hospital. When the nurse prefers to live outside the hospital, her compensation should be adjusted accordingly.

In order to attract nurses to the rural



and extremely isolated areas it was suggested that comfortable houses or flats should be constructed, if none are available. Inadequate living arrangements are frequently a barrier to recruitment for remote posts. Another plan proposed called for a rotation of personnel for a two- or three-year assignment to an isolated area and then return to a more populous area for a tour of duty. The giving of scholarships to selected prospective student nurses from the remote areas, with the understanding that following their training, they will return to the area to work for a stated number of years, was also proposed.

The Final Plenary Session was of considerable interest not only for the way in which presentation of group findings was handled to save time and preserve audience interest but also for the amount of spontaneous discussion afterwards from the floor.

Mrs. Lucile Petry Leone (USA) and Sir Arcot Mudaliar (India) summarized the sessions briefly. Again, I would hope that these summaries might be made available to us. Mrs. Leone did a very skillful job, clearly and unmistakably but without oversimplification, of linking improvements in nursing education with improvement in the quality of nursing services.

The Technical Discussions were not free from constructive criticism and that is as it should be. In approved "group dynamics" fashion, participants were invited to write brief comments on the value of the discussions and to make suggestions for possible future sessions. On forms provided, participants were asked to check their professional field of work but no signatures were requested. Of the 130 replies returned, 70 were from physicians, 60 from nurses. The replies from physicians and nurses were analyzed separately. General satisfaction was expressed with the discussions.

Thirty-seven of the physicians expressed satisfaction with the method used this year and suggested that this method be used for future discussions. Thirty-two liked the opportunity given for free and informal interchange of information and views on nursing problems. Four specifically mentioned how instructive the experience had been. The physicians' most frequent criticism was the shortness of the time and the breadth of the subject to be

discussed. Two replies stated that more emphasis should have been placed on the "practical" rather than on the "ideal."

In giving suggestions for future technical discussions, "earlier distribution of the documentation" was listed by 11 of the physicians. Nine suggested a more limited subject and nine recommended more time for technical discussions. Two hoped that the "next technical discussion would be as good as this one." Additional comments were made by individuals and these should be helpful to any future planning group.

The nurses were especially pleased with the background material and the preliminary discussions in the countries. Almost all commented on the value of free and informal discussion at an international level with their medical colleagues. A large number were pleased with the composition of the groups and the opportunity to meet with health personnel from such a variety of areas.

Their criticism, like those of the physicians, concerned the limited time to discuss such a comprehensive subject even though the discussions had been restricted to the education and role of the professional nurse.

Dame Elizabeth's final duty was to present the Report of the Technical Discussions at a Plenary Session of the General Assembly. As Technical Discussions are not an integral part of the Assembly there was no question of our Report being "adopted." It was, rather, *presented*, and "*notice taken of it*" (accompanied, I may tell you, by graceful tributes from the President of the Assembly, Professor Parisot of France.) Then the Report was deposited for inclusion in the official documents of the Ninth General Assembly, thus to go down into World Health Organization history.

In conclusion, I should like to share with you one or two personal impressions of the Geneva experience. I am not at all sure I can answer to your complete satisfaction or my own, these two questions:

- (1) What was really accomplished?
- (2) What does it all add up to for the future?

On the surface at any rate, *no new thing came out of Geneva*. Indeed there



were times when I felt: "The same old problems we've been grappling with for years: the same old clichés we've been repeating for a long, long time as we go round and round the mulberry bush looking for answers." No — perhaps there *was* nothing new, but I am not so sure but that *something new because of Geneva 1956*.

To me this is the inner and ongoing significance of these Technical Discussions. I could not but feel that because of the marked degree of interest shown by doctors as well as by nurses, together with the work done before, and the follow-up which is already being planned for in some areas of the world — the stimulus engendered at Geneva might well serve as a catalytic agent in a variety of ways and in a variety of places.

Geneva 1956 might be likened to a stone dropped in a pool. I prefer

the word I have used in my title — a signpost. This is a starker symbol perhaps than that of automatic, ever-widening circles — but perhaps it is more apt because it conveys the idea of responsible and deliberate choice rather than simple cause and effect. *A signpost points the way*. It serves no other purpose.

It is always a bit dangerous to assume, even for a brief moment, the prophet's mantle. Greatly daring, however, I am doing so to the extent of registering my conviction that, despite the differences in stages of development of nursing among the countries represented at the Technical Discussions (differences which made approach to a consideration of common problems sometimes difficult and at times well-nigh impossible), Geneva 1956 will be looked back upon in years to come as a signpost of no small significance.

## The Nursing School Library

DOROTHY G. RIDDELL

A GOOD LIBRARY is a vital part of any school of nursing. The old, out-of-date books have been replaced by basic reference texts in the fields of medicine, surgery, obstetrics, pediatrics, psychiatry and related sciences.

There are a sufficient number of copies on the shelves. The books are easily accessible and there is evidence that they are in constant use.

School of nursing libraries would never have come into being if there had not been a budget large enough to create them and live people on committees or interested instructors who were fully conscious of the value which the continual use of a library has in the learning process.

The publisher also has assumed a responsibility for the good library for he has made the best books known through announcements, bookstalls at conventions and through contributions to such libraries. His representative, as well, not only introduces new books but stimulates a keen interest

in them. When he calls at the school of nursing he takes on the role of an educational consultant, interested in a wise choice of books to meet a particular need. As a consultant, too, he must look ahead to determine what additional texts will be required to fill specific needs in an educational program.

For the representative to gain an insight into how applicable a book is, it is important that the instructor evaluate the books. Such an evaluation also provides a guide for the students as to the material to be found in the library. The instructor may always seek the help of other qualified and interested persons in preparing these reviews.

Yes, the good library owes its existence to an adequate budget, persons cognizant of the library's function and value, and students who realize that here is to be found the foundation of knowledge.

\* \* \*

Nothing in life is more wonderful than faith — the one great moving force which we can neither weigh in the balance nor test in the crucible.

— SIR WILLIAM OSLER

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Miss Riddell is Senior Inspector, Schools of Nursing, Nursing Branch, Ontario Department of Health, Toronto, Ont.

# Trenna Hunter, President

**I**N OLDEN TIMES, astrologers were hired by notable families to make a diagram of the eastern heavens as they appeared at the time of the birth of a child and, from this diagram, to prophesy the career of the infant. Though it is highly improbable that any such horoscope was cast for Trenna Grace Hunter on the March 8th when she was born in Brandon, Man., she has made a most interesting and successful job out of living.

School teaching attracted Trenna Hunter after she had completed her senior matriculation. Following a year at Normal School she went to Alberta and for some 12 years taught in rural and urban areas, including six years at Banff. Tall, robust and active, she enjoyed and participated in all the outdoor sports for which that resort area is justly famous — skiing, skating, swimming, hiking, badminton and tennis.

The astrologists would have agreed that she was fulfilling her destiny when, in 1936, Trenna Hunter enrolled as a student nurse at the Vancouver General Hospital. Graduating with honors three years later, she won the coveted Seldon Medal for her prowess in surgical nursing. Despite this distinction, the broad field of public health nursing proved a stronger lure and she enrolled

at the University of British Columbia immediately.

Armed with her certificate in public health nursing, which within a couple of years was exchanged for the degree of Bachelor of Applied Science (Nursing), Miss Hunter joined the staff of the Metropolitan Health Committee in Vancouver. Her outstanding qualities of leadership quickly ensured her promotion to the position of supervisor of affiliating students, both from the university and from local hospitals. She was also made responsible for the development of an industrial health consultant service.

The exigencies of war provided the next step in interesting experience. Miss Hunter was loaned to the B.C. Security Commission when a Japanese internment camp was opened in Vancouver in 1942. Exhibition buildings were equipped with rows upon rows of army cots, and very little else, to accommodate thousands of people. As nurse-in-charge over these unhappy evacuees, Miss Hunter was responsible for everything relating to their health and welfare. Her duties ran all the way from securing adequate supplies of soap and other toilet articles to the supervision of the construction of a 100-bed tuberculosis hospital. She used every bit of knowledge she had ever acquired about nursing, hospitals, carpentry, sewing, getting along with people and administration in this fascinating and unique job.

When, in 1944, the Metropolitan Health Committee needed a new director of nursing service, Miss Hunter's proven capabilities made her a natural choice. Under her expert guidance, the nursing service has matched the tremendous population thrust of the city in the post-war years. New divisions have been instituted, new areas embraced, new programs launched. In all of these developments Miss Hunter has been the mainspring that kept the service running smoothly.

A busy life, in truth, yet always there has been time, interest and energy for more. Since 1950, Miss Hunter has been a vice-president of the Canadian Nurses' Association. Her



*(Tony Archer, Vancouver)*

TRENNA G. HUNTER



election by acclamation to the presidency last June was a natural culmination to her years of leadership in our association. She will continue to lead us as she follows the destiny that im-

pelled her to choose as the theme for this biennium, "Into the future, open a better way."

Good luck, Trenna Hunter! We are with you.

## Radioactive Isotopes

V. SKERRY, J. MACLEAN, J. BLACK, M. KENNEDY, S. MACDONALD

**T**HE FOLLOWING IS A BRIEF SUMMARY of the nursing care of a patient receiving treatment with radioactive isotopes. This is not a learned discussion on radioactivity but rather a description of care gained from our own experiences and the knowledge we have acquired about radiological nursing. We have divided the subject into the following headings: history and development, types and therapeutic uses, essential precautionary measures and the actual nursing care of a patient receiving gold therapy.

### HISTORY AND DEVELOPMENT

We all know the story of the discovery of radium and uranium, made known more recently in the book and movie on the life of Madame Curie.

Radium owes its name to the fact that it constantly radiates energy. These radiations are due to a disintegration within the radium itself, but the process takes 1690 years even to cause it to be one-half disintegrated. These radiations come off in three types of rays: (1) *Alpha rays* — which can be stopped by a sheet of paper; (2) *Beta rays* — which go through one hundred times the thickness of a sheet of paper, or one layer of cells; (3) *Gamma rays* — which have great penetrative power and will pass through thick layers of metal. They also pass through tissues, through the body and beyond the body.

Some of these rays of radium will destroy tissue and can penetrate deeply. If they are used in particular ways,

they can be made to destroy abnormal tissue, as in tumors. The release of energy is due to the expulsion of a particle from an atom which is trying to stabilize itself.

Radium is extremely expensive due to its great scarcity. The cost is \$20,000 per gram, or about \$600,000 per ounce, which, of course, would be a large amount of radium.

This is an old story, known to all. We are just using it as an introduction to some newer substances which are used at our hospital for the same purpose — that is, in treatment of cancerous growths or tumors. Presumably these substances will be used more widely as time goes on for diagnosis as well as treatment.

We read a great deal in the papers about the Cobalt bomb, about radioactive isotopes, and about the peacetime use of atomic energy. Much of it seems very vague and over our heads. But when we found there was something that was going on in our own hospital, we felt it was time for us to learn a little about it to be able to tell others. Some of our findings are:

It is possible to make some substances artificially radioactive, that is, capable of emitting rays of energy similar to those radium and uranium produce. This is a highly technical procedure and it will be sufficient to say that certain substances such as gold, phosphorus and iodine can be made radioactive by being bombarded with very small particles possessing terrific amounts of energy. Machines called cyclotrons were developed for projecting these bombarding particles upon targets or substances to be made radioactive.

The artificially radioactive sub-

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These five students from Victoria General Hospital, Halifax, presented this topic at a session of the annual meeting of the Registered Nurses' Association of Nova Scotia last June.



stance has the same chemical properties as the stable material, but a different atomic weight. Due to the rearrangement of the neutrons in the nucleus, this isotope is now unstable and, in trying to stabilize itself, it gives off radioactivity. These substances differ from radium in that the radioactivity is usually quickly lost. In some instances it is lost in a matter of days; in some, a matter of hours or even minutes.

Since any radioactive substance takes an infinitely long period of time to completely lose its activity, the time taken to lose half its radioactivity is a more reasonable and useful property and this is known as its half-life. Some half-lives are long — Radium 1690 years; some are short — Gold 2.8 days; Iodine 8 days. At the end of the half-life, the material is only half as radioactive as it was at the beginning of the period. For instance, radioactive gold has a half-life of nearly three days, that is to say, at the end of that time it retains only half its original activity. At the end of another three days, only a quarter of its original activity and by the end of nine days only one-eighth of its original activity is retained. Thus, the material loses half its activity at the end of every half-life but it would take forever to completely lose its radioactivity.

The Beta rays of these radioactive isotopes are used in radiation therapy. These are the ones that will go through a few thicknesses of paper. More than that, they are absorbed by the tissues where they continue to lose their radioactivity.

By their very nature radioactive isotopes are potentially dangerous to patients, doctors and nurses, and should be used only by those having a sound knowledge of the physics of radiation and the biological effects of ionizing radiation on man.

#### TYPES AND USES

In considering the different types of radioactive isotopes, we shall note a few of the various types in use at present and in what conditions they have power to be most helpful in diagnosis and therapy.

*Radioactive Colloidal Gold*, Au 198, is used primarily for injection into the pleural or peritoneal cavities. The

presence of new growths or metastases in these cavities may cause large amounts of fluid to accumulate. In the early stages, the condition may be controlled by aspiration, drugs or external radiation. However, it inevitably recurs and the patients may be miserable from the pressure of the fluid, while the actual cancerous growth causes negligible symptoms. The injection of radioactive gold, directly into the body cavity containing the fluid, may result in prolonged control of fluid production and a much more comfortable patient. The cancer is not cured, but one of its manifestations is brought under control temporarily. While this may seem to be only of relative benefit, the patient may derive a new lease on life since it allows him periods of normal activity.

*Radioactive Iodine*, I 131 has become of importance in thyroid cancer, hyperthyroidism and in anginal attacks. One of the most widely explored fields in isotope work in cancer is the use of radioactive iodine-tagged albumin to locate brain tumors. It has proven to be about 70 per cent accurate. This method allows the presence of a brain tumor to be determined without the need of an exploratory operation.

*Radioactive Phosphorus*, P 32, has become the treatment of choice for polycythemia vera. While this is not a true form of cancer, secondary complications have been known to cause death. Radioactive phosphorus, x-ray and chemicals have made it possible to control polycythemia, so that these patients have the same life expectancy as those with well treated diabetes, or pernicious anemia. P 32 is being used also in the treatment of chronic leukemia as a maintenance therapy. It has not proven to be of any value in the treatment of acute leukemia.

Radioactive isotopes can be used in shielded units as a source of radiation similar to that available from radium or a high voltage x-ray machine. The isotope which is considered here is *Cobalt 60*. It has many vastly important advantages over radium, in its quality of radiation, and the flexibility of its use.

We have considered the artificial man-made isotopes up until now, but radium is a natural radioactive isotope,

with which we are all familiar. In this hospital we use a great deal of radium in gynecology, and in cancerous growths of the face, nose, mouth and in superficial cancerous lesions. Radium remains an exceedingly useful therapeutic substance and has as yet not been completely replaced by man-made radioactive materials. With the artificial isotopes, however, diagnostic procedures and new research procedures are being developed that seemed impossible before the advent of the atomic age.

#### PRECAUTIONARY MEASURES

Nurses working with radioactive isotopes frequently ask the question: "What are the dangers to me?" This is natural, for the potentially dangerous radiations emitted by radioactive isotopes can neither be seen, felt nor smelled and one may become lax about the use of proper precautions against such an obscure foe.

A device called a "film badge" is worn by every person working near radioactive elements. This is a black plastic box containing a paper covered film. The amount of blackening on the film, found after development, changes with the amount of exposure to the radiation. Usually every two weeks the film is developed and the amount of the wearer's exposure to the radiation is determined.

There are many ways a nurse may be protected from radioactive rays, such as keeping her distance from a radioactive patient unless she is actually doing something for him, by wearing rubber gloves when handling contaminated material, for example a bedpan containing radioactive urine, or by using tongs when handling radioactive materials directly.

Radioactive isotopes should not be used nor handled by persons with cuts or open wounds on the skin. Because of the dangers of ingestion there should be no smoking nor eating in the area of radioactivity.

Following the injection of colloidal gold, all linen used for the set-up, gloves, syringes, etc. found to be contaminated by using a Geiger counter, are put in the room with the patient for as many days as is necessary for the radioactivity to subside to a safe level.

The patient is allowed to use his own bathroom, as the amounts of radioactive substance excreted at any one time are not dangerous. The toilet should be flushed immediately.

These are a few of the most important precautionary measures which should be carried out when working with radioactive isotopes.

Careful research has indicated what can be regarded as a harmless dose. This amount, divided by ten, is taken as the maximum dose for a worker in one week. This is carefully recorded by the film badge.

Extensive repeated over-exposure to radiation may cause: nausea; loss of hair; blood changes; sterility; death.

The degree of radioactivity the nurse attains as she works near the patient depends on two things — first, the type and amount of isotope; second, the distance the nurse is from radioactive material in the patient. Therefore, the key to control of absorption by the nurse depends upon (a) the distance she is from the radioactive patient and (b) the amount of time spent in actual contact with him.

#### GOLD INSTILLATION AND NURSING CARE

Radioactive Colloidal Gold is used in the treatment of pleural and peritoneal effusion arising from malignancy. The therapeutic principle is the reduction of the ascitic fluid formed. The colloidal gold, when introduced into the pleural or peritoneal cavity, causes irradiation of the serous membrane; the gold becomes plastered over the surface of the cavity. For a peritoneal injection an administration of Pantapon is first given. Following this, an abdominal paracentesis is done with a special trocar and cannula. After as much fluid as possible has been removed, 100 cc. of sterile normal saline is run into the cavity followed by the colloidal gold. Three rinses of saline through the gold container are then instilled into the cavity plus the remainder of the litre of saline. The cannula is then removed and the puncture sealed.

Following this administration the patient is returned to a special room on fourth floor of our hospital, chosen because no work is carried on in the rooms adjacent to it.



For four hours the patient is postured at 15 minute intervals. These postural changes, from side to back to side, ensure diffusion of the colloidal gold throughout the cavity. For the next four hours the patient is postured at half-hour intervals.

Following this period, no specific bedside care is indicated, other than treatment of nausea and vomiting. In some cases Pyrodoxine or Gravol is used. Nutrition is an important factor and the patient must be encouraged to eat, although loss of appetite is common. A diet rich in nutritive elements is essential.

The nursing care of a patient being treated with radioactive materials must be founded on an appreciation of the patient's mental, emotional and physical needs. The importance of this understanding is heightened by the fact, that during the first 24-hour period actual nursing care must be limited to 10 minutes per hour. It is obvious that maximum use must be made of these brief periods, to care for the emotional as well as physical needs. The patient must not be allowed to feel that he is being avoided nor neglected. His sense of hope, as inevitable as that of fear, is valuable and may be strengthened by a sincere and reassuring attitude on the part of the nurse, rather than by false optimism. As in any form of treatment a complete explanation of the procedures employed and of the patient's external and internal reactions is essential. The apprehension and withdrawal of the patient may greatly undermine the ultimate success or failure of the therapy.

Public patients remain in the fourth floor room for five days; private patients may return to a single bed room after 72 hours. By this time radiation has decreased enough to minimize any risk.

With the ancients I believe that as a man speaks, so is he. Therefore will I live aware of my world: having a listening ear, a seeing eye, an understanding heart and an expressive tongue. I will pay as much attention to my address as to my dress, for words are power. I acknowledge them to be the flowering of the mind, the message of the heart, the ambassadors of the soul. Nor

Local pain at the site of injection up to 48 hours is a common symptom following colloidal gold instillation; nausea and vomiting may occur up to 72 hours, and a temperature elevation to about 100°. A neutrophilia occurs in 10-18 days and in 20-30 days there is a fall in hemoglobin.

Colloidal gold therapy is administered only to essentially fit patients. Its effectiveness in terminal stages of disease is likely to be slight.

Gold therapy was first used in this hospital in July, 1955. Its ultimate success can scarcely be realized at this point. However, with continued usage in the future, it is hoped that some relief from pain and discomfort may be obtained by patients with malignant disease.

In conclusion, radioactive isotopes do not cure cancer, but they relieve pain and discomfort associated with it, and help to locate malignant metastases.

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will I be guilty of speaking idle words, guarding my tongue as a door unto a treasure-house wherein dwells wisdom bought with knowledge and experience, tolerance purchased by failures, compassion paid for dearly out of suffering. Therefore, if I speak at all I will speak clearly and in good taste, simply and effectively, in the correct use of our mother tongue. — Selected



# NURSING PROFILES

**Alice Girard**, as first vice-president of the Canadian Nurses' Association, will lend able assistance to our national executive in guiding professional affairs. Completely bilingual, she is a graduate of St. Vincent de Paul Hospital, Sherbrooke, Que. and holds her certificate in public health nursing from the University of Toronto. In addition Miss Girard secured her B.S. degree from the Catholic University of America, Washington, D.C. In 1944 she completed studies for her Master of Arts from Columbia University.

With this background of professional preparation, she has, quite naturally, been called upon to fill responsible positions. From 1942-47 she assumed directorship of the School for Public Health Nursing, University of Montreal. Miss Girard left this position to become superintendent of the nursing services of the Metropolitan Life Insurance Company in Canada. She is now the gracious, capable director of nursing at Hôpital St. Luc, Montreal. During the past biennium, when she was second vice-president, she was also chairman of the nursing service committee.



ALICE GIRARD

**Helen M. Carpenter**, the new second vice-president, is no stranger to the duties inherent in membership on a national executive. A graduate of Toronto General Hospital and the University of Toronto, her interests have centred on every phase of public health nursing. Her preparation for this particular field has fitted her admirably for the active

role that she has and is taking. Following eight years' service with the Victorian Order of Nurses in Hamilton and Toronto, she was awarded a T.G.H. alumnae scholarship. She went on to Columbia University receiving her B.S. degree in 1943. At the end of one year as consultant in public health nursing with the B.C. Board of Health, her ability was further recognized when she was made the recipient of a Rockefeller Fellowship. Miss Carpenter secured her M.P.H. from Johns Hopkins University in 1945.

She next assumed the dual role of lecturer at the University of Toronto School of Nursing and supervisor of the nursing service of the Department of Health of East York Township. She is presently full-time on the University faculty. Actively interested in professional affairs, she has served as chairman of the Public Health Section of the Canadian Public Health Association and held the same office with the former CNA Committee on Public Health Nursing.



(Ballard & Jarrett, Toronto)

HELEN M. CARPENTER

A Maritimer of Scots descent, **E. A. Electa MacLennan** fills the position of third vice-president. Director of the school of nursing at Dalhousie University, she has had a breadth of experience in the field of nursing that makes her a valuable member of the executive team. A graduate of the Royal Victoria Hos-

pital, Montreal. Miss MacLennan received her certificate in teaching and supervision from McGill University in 1933. At the end of two years with the Montreal branch, Victorian Order of Nurses, she joined the staff of Vancouver General Hospital as clinical instructor and junior administrator in 1935. In 1937 she rejoined the V.O.N. first as a staff nurse then as a National Office supervisor before going on to Columbia University to obtain her Master of Arts degree. Once more she returned to the Victorian Order, this time as supervisor in the Eastern Canada area. In 1946 she joined the faculty of the McGill School for Graduate Nurses as assistant director and assistant professor in public health nursing, leaving this post for her present one in 1949. This year she was elected a Fellow of the American Public Health Association.

The Canadian Nurses' Association has previously benefitted from her enthusiasm and energy when she took charge of publicity work during her tenure as assistant secretary in our National Office, 1944-46. Her canny knowledge of matters pertaining to nursing will serve us well again.



(Dodge, Halifax)

E. A. ELECTA MACLENNAN

**Sister Mary Felicitas**, whose unflinching interest in professional matters is a byword to her confrères, will represent sisterhoods of the Quebec region. A graduate of Providence Hospital, Moose Jaw, she later obtained her B.S. degree in nursing education from the

University of Ottawa and her Master's degree from Catholic University, Washington, D.C. Prior to assuming her present duties, Sister was obstetrical supervisor in her home school and then, for a short period, assistant superintendent. As a member of the A.N.P.Q. Board of Management, the advisory committee of the former Montreal School for Nursing Aids, the Editorial Board of *The Canadian Nurse* and numerous other committees, she has given freely of her knowledge and experience.



SISTER M. FELICITAS

**Sister Mary Frances de Sales** will continue to represent the Ontario sisterhood as she has done so ably since 1952. Sister is on the teaching staff of St. Michael's Hospital, Toronto as nursing arts instructor. A graduate of St. Louis University, she holds her B.Sc. in nursing education.

In tribute to her capabilities, **Sister Helen Marie** was re-elected to represent the nursing sisterhoods of the Maritime Region. Sister is director of nursing at St. Joseph's Hospital, Saint John — a post she has held since 1948. A Maritimer by birth, she received her early education in New Brunswick before undertaking her professional training at Holy Family Hospital, Prince Albert. She secured her B.S. degree in nursing education from the University of St. Louis, Missouri. Experience as a staff nurse and supervisory duty in obstetrics, and medical and surgical nursing preceded appointment to her present position. The Committee on Institutional Nursing for N.B. and the executive of the N.B.A.R.N.

have both welcomed her contribution in discharging their responsibilities.



SISTER HELEN MARIE

Adding another duty to a busy professional life, **Sister Mary Laurentia** has been chosen to represent the nursing sisterhoods of the Western Regions. A graduate of St. Vincent de Paul Hospital, Brockville, Sister obtained a certificate in clinical supervision, specializing in obstetrical nursing, from the University of Toronto. She has had wide experience in supervisory positions in operating room, obstetrical and medical nursing fields. At different times she has been associated with St. Francis General Hospital, Smith Falls,

Ont.; St. Mary's Hospital, Camrose, Alta.; Providence Hospital, Daysland, Alta.; St. Joseph's Hospital, Edmonton. At present Sister is obstetrical supervisor and clinical instructor at Providence Hospital, Moose Jaw.

A lively interest in provincial affairs has won for her the office of vice-president of the Moose Jaw Chapter, S.R.N.A., and of the local unit of the Saskatchewan Council of Catholic Nurses. She has held office in the Catholic Hospital Conference of Saskatchewan for a period of four years — first as vice-president then as president — and has served on the provincial Board of Examiners.



SISTER M. LAURENTIA

## In Memoriam

**Mary A. Atkinson**, who graduated from the Toronto General Hospital in 1912, died suddenly in June, 1956 at Toronto. Until the last two years, Miss Atkinson had been active in nursing ever since graduation.

\* \* \*

**Mary Caroline Beckett**, a native of Ontario who trained and worked in the United States over half a century ago, died at Phelps-ton, Ont., on May 16, 1956 in her 90th year.

\* \* \*

**Mary Helen Caldwell**, a Nova Scotian

who trained in Worcester, Mass., died at Halifax on June 13, 1956 following several months' illness. For many years Miss Caldwell engaged in district nursing in Spencer, Mass., turning to private nursing when she went back to Nova Scotia in recent years.

\* \* \*

**Lavinia Lloyd Dock**, a graduate in 1886 of the Bellevue School of Nursing, New York, died on April 17, 1956 at the venerable age of 98, following a fracture of her hip. Well known to the older generation of nurses





## “Better physical condition when fed meat early . . .”

**I**N a study conducted by Leverton and Clark “Meat in the Diet of Young Infants”, (J. A. M. A., 134,1215 (1947), special prepared meat was added to the formula of full-term babies beginning at the age of six weeks and continuing for a period of eight weeks. The pediatrician in charge considered that the babies were in better physical condition generally as a result of the meat supplement. Nurses in attendance reported that the meat-fed infants seemed better satisfied, slept well and cried little.

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*cooked and milled to a fine purée. The texture is soft, moist and easily fed in formula or for initial spoon feeding just as it comes from the can. There are seven kinds for variety and special conditions: Beef, Lamb, Pork, Veal, Liver, Heart, Liver and Bacon, and also Swift's Egg Yolks for Babies, Salmon Seafood for Babies and the chopped Swift's Meats for Juniors.*

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as co-author, with Miss Nutting, of a History of Nursing, Miss Dock's keen and penetrating mind had lost little of its vigor with advancing years. Her ability to use words with a purpose made her numerous writings masterpieces of leadership in promoting professional affairs. Through her long years as Honorary Secretary of the International Council of Nurses — from 1899 to 1924 — her enthusiasm for worldwide understanding among nurses bore fruit that, happily, she lived to see mature.

\* \* \*

**Katherine Dyck**, who graduated from Saskatoon City Hospital in 1949 was one of two Canadian nurses who were drowned on August 2, 1956 when high waves dashed them off rocks near Pusan, Korea, and pulled them to sea. Miss Dyck had worked in several places in Canada before going to Korea in 1954 to serve with the Mennonite Central Committee at Ilshin Women's Hospital.

\* \* \*

**Effie Helen Forgie**, who graduated from Toronto General Hospital in 1920, died at Toronto on June 3, 1956. During her 36 years in active nursing she had served as a supervisor at Fifth Avenue Hospital, New York, General Hospital, Simcoe, Ont., the Private Patients' Pavilion, Toronto General Hospital, and latterly, as superintendent of the Hillcrest Convalescent Hospital, Toronto.

\* \* \*

**Annie (Smith) Fraser**, who graduated from the Royal Victoria Hospital, Montreal, in 1925, died there on August 5, 1956 following a lengthy illness. Prior to her marriage, Mrs. Fraser was head nurse on a medical ward at R.V.H.

\* \* \*

**Jean Elizabeth (Alexander) Johnson**, who graduated from Toronto General Hospital in 1926, died at Hamilton on April 17, 1956.

\* \* \*

**Bertha Kornelson**, a graduate of Vancouver General Hospital, was the second drowning fatality at Pusan, Korea. She was on the staff of the Pusan Children's Charity Hospital at the time.

\* \* \*

**Marie Brigitte Laliberté**, who graduated from St. Jean de Dieu Hospital, Montreal, in 1927, died suddenly on August 7, 1956, at the age of 49. After two years of service in a hospital in New Jersey, Miss Laliberté joined the staff of the Montreal Department of Health, Mental Health Section. She became supervisor of this section in 1940, assistant director of nursing services in 1945 and in



BRIGITTE LALIBERTÉ

1949 was named the director of nursing services.

\* \* \*

**Lila M. Langford**, chief of the collegiate nursing staff in Ottawa, died at Leamington, Ont., on July 11, 1956 after a month's illness. Before moving to Ottawa, she was with the Victorian Order of Nurses for some years serving at Waterloo and at Kirkland Lake, Ont.

\* \* \*

**Mary Carolyn (Peppler) Lippert**, who graduated from the Toronto Western Hospital in 1943, was instantly killed on July 9, 1956 in an airplane accident. Prior to her marriage, Mrs. Lippert was on the staff of the Hospital for Sick Children, Toronto.

\* \* \*

**Cecelia Eileen McGuire**, who graduated from New York City Hospital in 1925, died at her home in Toronto on June 29, 1956. As an instructor and the director of nursing she had served at several hospitals in New York, Wisconsin and the New England states.

\* \* \*

**Adeline Mary Page**, who graduated from Toronto General Hospital in 1893, died there on July 13, 1956 at the age of 92. Miss Page had worked in many places before she retired 20 years ago.

\* \* \*

**Violet (Stevens) Paterson**, who graduated from Toronto General Hospital in 1925,

(Continued on page 834)

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# The Role of the Nurse in Rehabilitation

ELISABETH C. PHILLIPS, B.S., M.A.

THE CONCEPT OF REHABILITATION is wholly dependent upon the attitude of society towards it. Since the last war the attitude of many members of the patient-care team has been one of increasing consciousness of the value and needs for better rehabilitation methods. Society as a whole is also responding to the efforts of rehabilitation enthusiasts, and monies and facilities are being made more freely available.

Too many times the nurse as a member of the patient-care team has not been aware of the role that she *should* play nor have many of the other members of the team felt that the nurse's part was at all vital. To date there seems to be very little written concerning the nurse's role and only feeble efforts have been made to teach her to discharge her responsibilities well. We do not yet really know what the scope and limitations of the nurse in rehabilitation of patients can or should be and it is high time that we found out.

Perhaps some of the difficulty lies in the fact that rehabilitation and vocational placement of the handicapped have been thought to be synonymous by many. Of course, nurses are *not* prepared to help in vocational placement, but rehabilitation is *much more than placement*. Placement is, indeed, but one facet of rehabilitation and it usually comes near the end of a long chain of events. Gainful employment is of course, the goal of many rehabilitation programs, but it is far from being the *only* goal. Much needs to be done to bridge the gap between the bed and the job, and it is in these

phases of rehabilitation that the nurse can become a vital team member.

Long before a handicapped person is ready for job placement, he must have mastered the rudiments of self-care. Self-care, as an important objective of rehabilitation, is justified medically, psychologically, socially and economically, as well as in a vocational sense. Dr. Howard Rusk,\* has pointed out:

Lacking specific measures in the cure of many chronic diseases, medicine must look to rehabilitation to teach those afflicted by disability to live and to work as effectively as possible with their remaining physical abilities. Until medicine finds the answer to and specific treatment of the problems in the diseases of the heart and circulation, rheumatic fever and arthritis, cerebral palsy, multiple sclerosis, poliomyelitis and the other crippling diseases, we must utilize the techniques of physical rehabilitation, psychology, social service, vocational counselling and the auxiliary specialties, to teach the disabled to live within the limits of their disability but to the full extent of their capabilities . . .

Except in a few isolated instances, the physically handicapped person must be retrained to walk and travel, to care for his daily needs, to use normal methods of transportation, to use ordinary toilet facilities, to apply and remove his own prosthetic appliances, and to communicate either orally or in writing. Too frequently these basic skills are overlooked. The patient is given numerous medical, psychological and vocational services in preparation for employment or self-care, but retraining

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Miss Phillips is Executive Director, Visiting Nurse Service of Rochester and Monroe County, New York. This is the last of her series of papers.

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\*Howard A. Rusk in the Foreword to "Physical Rehabilitation for Daily Living" by Edith Buchwald — first edition, McGraw-Hill Book Company, 1952.



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in the activities of daily living is overlooked — with the result that the patient, being unable to walk and travel and care for himself, is also unable to utilize effectively the other medical, psychological, social and vocational services he has received, for richer and fuller living. Retraining in the basic activities of daily living is primary; it is simply a matter of "first things first," for daily activity skills are the basis for all subsequent activities.

The nurse has a unique opportunity, for rehabilitation *should* really start at the time of the onset of the disability or crippling condition. What other members of the patient-care team have such an early and continuing contact with the patient as do the generalized physician and nurse? The staff nurse spends a far greater number of hours at the patient's side early in the episode than does any other professional member of the team.

Do her ministrations really lead to rehabilitation? I wish I could give an unqualified "yes" to this question, but it is not so. I am not saying that the nurse does not save life or that she does not promote recovery. She does. But she could do so much more had she but the right rehabilitative viewpoint and rehabilitative know-how.

It is a fact, that her role, as she sees it, is nearly devoid of rehabilitative activities. Too often what she does for the patient actually delays rehabilitation by making him more dependent on others than his handicap justifies. We used to think the typical "good nurse" did everything for and to her patient, rather than to help him to do things for himself. She bathed him; sometimes she fed him; she picked up the newspaper he let fall to the floor; she adjusted his prosthesis for him; she took him for a ride in a wheelchair; she helped him to do this and that; she stood between him and reality; she stood between him and life as he must live it. Today, we are beginning to think that "good nursing" is something quite different.

Few situations hold more challenge for a nurse than the care of a patient who is chronically ill, yet there is no type of patient that the average nurse wants less to have the responsibility for nursing. Probably one of the

reasons for this is that she feels quite insecure in caring for a long-term patient. All of her professional education has been directed to the care of the acutely ill; hence she is less certain of her relationship to the long-term patient. In many respects, large numbers of the nursing needs of chronically ill patients are the same as those of the acutely ill, but there is a whole pattern of care which is peculiar to long-term illness which needs to be understood and mastered. The progress of the patient may depend just as much on the nurse's insight into the meaning of this pattern as on the physical care she gives him.

Acute illness, is, of course, a disturbing situation for both the family and the patient, but when an illness becomes chronic or leaves a person permanently disabled, the emotional hazards and related problems are even greater. The patient's and his family's whole plan of life have been changed and probably will always have some degree of change in it. Obviously, the greatest impact of chronic illness is upon the patient himself. The loss of his capacity to function as a normal, independent, physically active, productive member of his family strikes an almost mortal blow to his personality. The problem for the nurse is to soften the effects of this blow and to help him to regain his ability to function normally insofar as it is possible for him to do so.

In order to do this the nurse must foster an atmosphere of normality about the patient to the fullest extent that his condition permits. In normal life, self-direction is a major characteristic; therefore, the nurse should consult the patient when questions arise or problems need solving regarding him personally. Nothing will frustrate him more than to have his life ordered for him when previously he has been accustomed to making his own decisions and leading an almost independent existence. Although his life is now going to be quite different from what it was before, the patient should be given an opportunity to plan as much of it as he possibly can and to participate in *all* of the decisions that affect him. To be dependent on another individual affects our personal dignity, and is a blow to our ego. The



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person with a long-term illness is essentially the same person that he was before he became ill, with the same character traits, the same likes and dislikes, the same personality, and usually the same mental capacity.

Another thing that will foster the atmosphere of normality is to see that the patient is dressed as he normally would like to be when he appears before other persons, particularly other members of his family or his friends. It takes more time, of course, to help a patient get dressed, fix her hair, put on her cosmetics, fix his tie, and so on, but the returns from this investment in time, as measured in the morale of the patient, are tremendous.

Have you ever stopped to think of the indignity of a bedpan or how important it is to a person to have a tub bath or shower in much the same way that he did prior to his disability?

The use of perfume, jewelry, good-looking pyjamas or a pretty dressing-gown, and all those other things that we feel are important to keep up our self-respect are immeasurably *more* important to the person with a long-term illness than they are to those who are not incapacitated.

If the patient is at home he may still be as removed from the life of his family as he was while he was hospitalized. One of the tragic aspects of family life is that it is so easily possible to make a member of the family feel an outsider. There are, of course, many difficulties attendant upon bringing a person with long-term illness into all aspects of family life, but wherever possible these difficulties should be overcome. Having a patient come to the table to eat with the family or participate in some of their entertaining is often possible if thought and preparation is devoted to it before asking him to do so. The well-meaning family so many times wants to wait upon the incapacitated member. In the beginning they are only too glad to do this, but as time goes on and because he is so dependent upon them, the patient begins to be a burden. Usually he is the first to realize that this is so. Chronically ill people need to have responsibilities which they are capable of discharging — responsibilities that contribute to family and community life.

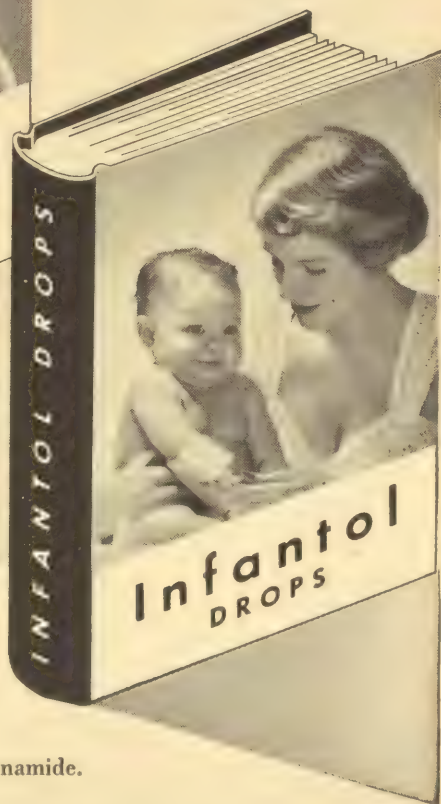
A rather diligent search of current literature reveals little that serves as a delineation of the role of the nurse in the care of the long-term patient. Sometimes we see statements made indicating that practical nurses or nursing aides should be taught to give care to such patients and the implication is that their ministrations are all that are required. Sometimes it appears that the nursing care of the chronically ill resembles closely that needed by acutely ill patients. One of the most charitable descriptions of the care given such patients by a visiting nurse reads thus: "The nurse should bathe the patient, change his surgical dressing if needed, give an enema, hypodermic or intramuscular injection, if ordered, and teach the patient how to guard his health and show the family how to care for him." All this is true, but how insipid it is in its limitations! This, indeed, is a description of palliative nursing only, not dynamic care. The chronically ill do need dynamic, constructive and imaginative nursing. Of this I am sure!

Rehabilitation nursing is receiving more and more attention today, yet the whole idea of its practice is old. As we look back over the history of nursing we find that some of the objectives of nursing, as we know them today, were better realized in years gone by than they have been recently. Unfortunately, this is true with regard to rehabilitative emphasis. Perhaps this surprises you, but it need not. Nurses 50 years ago did not use the word "rehabilitation," but their objective was much the same as ours today. Miss Lillian Wald, the founder of the Henry Street Visiting Nurse Service in New York gave a report before the Eighth Annual Meeting of the Associated Nurses' Alumnae of the United States and Canada in 1904. She called her paper, "The Treatment of Families in which there is Illness," and this in part is what she said:

An Italian was visited by one of the nurses. He had recently returned from Bellevue Hospital where he had been for many weeks. The family consisted of father, mother, two boys and two girls. The patient was paralyzed below the waist and had undergone several operations; he was also suffering from three large bed sores. He was lying on a hard



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cot with one sheet over him and only rags beneath. The wife sat by the window sewing knee pants. This was the only means of support for the family.

The first thought of the nurse was removal to a hospital, but upon talking with him, she found that he had been very unhappy in Bellevue Hospital and absolutely refused to return to it. The nurse then secured an air bed for him and loaned sheets, pillow cases and night clothes. She persuaded friends to provide nourishing food. The mother sewed while daylight lasted and when it became too dark to sew she washed the sheets, pillow cases and night clothes that the nurse might have clean linen the next day.

This condition continued for several weeks when the mother began to show signs of being rundown from exertion. Again the nurse pressed the hospital, the patient still refused, but at last said he would go to any hospital but the one where he had been before. As this was the only hospital that would take him in, the situation seemed hopeless. The only way in which he could have been taken to a hospital was by physical force. We felt that it was a cruel thing to insist upon his going when he begged persistently to be left at home and said his only prayer was that he might die at home with his family.

We, therefore, made arrangements for assistance to the wife in housekeeping and sewing that she might herself nurse her husband. When the nurse told the family that such arrangements had been made, the man was overcome with emotion and fainted. He lived only a few weeks but died as he wished, at home.

This paper was read in 1904 yet it shows the definite attempt on the part of the public health nurse to rehabilitate this *family* although the actual technique of rehabilitation of the paraplegic was still unknown. Of course, she did not think she was carrying out rehabilitation nursing. Had she been asked, she probably would have said that she was simply trying to get the family back on its feet.

We have gone through a period in which we lost sight of many important phases of nursing as we concentrated our attention upon the disease rather than the patient. Modern nursing is concerned with the whole patient and with his reaction to his ill-

ness. Today's nurses should no longer be satisfied to be concerned with the disease alone.

Sometimes I think that we carry out much more rehabilitation nursing than we give ourselves credit for. The nurse who teaches a patient who has had a colostomy how to carry out his normal life pattern, is certainly doing rehabilitation nursing. So is the nurse who teaches a postpartal patient the importance of correct posture and helps her to achieve it. This, too, is rehabilitation although not of such a dramatic form.

Certainly rehabilitation nursing should be part and parcel of generalized nursing care whether that care is given in a hospital or at home. It should be available to all patients, not just to a limited few. There will be some patients who will not need this specific help in its widest sense, but we must realize that almost all patients need some type of rehabilitation nursing at some point in their convalescence. One of the reasons often given against specialized rehabilitation institutions and specialized rehabilitation staffs is that an implication is made that no efforts need be made to rehabilitate all patients, by all who care for them.

The ultimate aim of rehabilitation is to restore the handicapped individual to the fullest physical, mental, social, vocational and economic usefulness of which he is capable. Rehabilitation nursing is a continuous process beginning at the onset of the illness or even before it, in the preventive nursing care which should have been available. It continues during the illness and is part of the definitive measures that are taken for arresting the disease. Then it continues into the third phase of the care which is often called rehabilitation itself.

Rehabilitation nursing calls upon all the fundamental techniques and skills that the nurse has mastered for giving general bedside care. It also is dependent upon specialized rehabilitation techniques. Unfortunately many times our schools of nursing are not in a position to teach these specialized rehabilitation techniques. Perhaps it is because too few hospitals have rehabilitation departments in which the student nurse can have experience.

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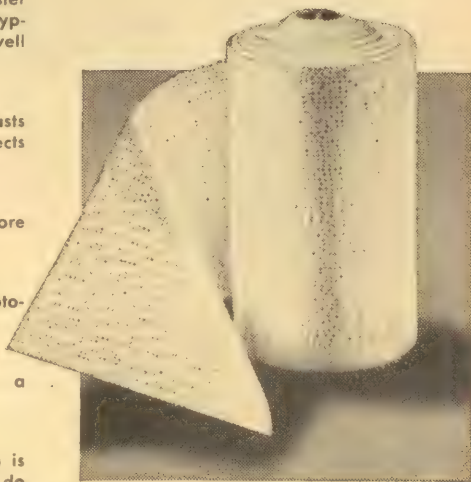
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Probably it results from a more fundamental reason. In far too many of our hospitals the emphasis is put on the care of the acutely ill rather than upon care for those who have a long-term illness. Progress is being made, however, in helping the young student nurse to understand preventive measures for many diseases and disabilities.

We have a long way to go to help our nurses develop rehabilitation skills. My own agency accepts undergraduate nurses from five different schools of nursing. We are continually amazed at the lack of understanding which these senior students seem to have regarding the way in which we teach patients how to use crutches. This is such a universal failing that we have now incorporated, not only the methodology of doing this, but also an hour in which the students practise walking on crutches and in so doing, learn many of the points which they must incorporate in their teaching of patients if the outcome is to be satisfactory. Fortunately some of our student nurses are learning some of the ways that braces and prostheses should be applied and used. Again, this varies materially from one school to another. Probably no school includes, in the basic curriculum, anything that prepares the nurse to participate in speech therapy for a patient who has had a cerebral vascular accident. Yet how many times might she use this knowledge to advantage while she is giving

other types of care to the patient!

Teaching of self-care activities is another thing we have left out of too many of our curricula. Emphasis still seems to be on teaching the nurse how to do things *for* the patient rather than teaching the nurse *how to help patients do things for themselves*.

The greatest need for many patients is motivation. We achieve motivation by convincing the patient that he *can* regain or compensate for much of his lost power. To do this we must have a personal conviction that this is so. We must know how it can be done, how long it is likely to take and what effort must be expended in order to do it. Above all this must be done early in the course of treatment, long before the patient develops an attitude of dependence. This is not the sole responsibility of the nurse, but she is a key person.

Howard Rusk has stated that the true aim of rehabilitation is to train the patient to live within the limits of his disability, but to the hilt of his capacity. That capacity often surprises the patient, the physician and the nurse. Rehabilitation measures as we know them today are especially applicable to patients with polio, spinal cord injury, cerebral palsy, arthritis, speech disorders, amputation of a limb and cerebral vascular accidents. Aren't we really selling such patients "short" when we fail to include rehabilitation activities in our nursing care?

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"No rational man can deny the basic physical changes which have occurred in our universe in the last hundred years. It now takes less time to girdle the earth than it took during the eighteenth century to travel from Boston to Philadelphia or from Edinburgh to London. Even if still only a small fraction of mankind uses the new means of transport, the physical interconnectedness of those who stay at home is equally a fact. The Malayan peasant's decision whether or not to hand food through the stockade to a Communist guerrilla may be determined by the opening or closing of an artificial rubber factory in the United States. The chocolate eaters in Lon-

don and New York help to fix the income of cocoa farmers in the Ashanti. However violent the effort made at various times — for instance in the thirties — to insulate national economies from the forces of change or development or collapse at work in world trade, the web of commerce has grown so strongly that today the nations appear to have only two choices: either to make the intricate system function or else to strangle in its tangled skein."

The foregoing, from Barbara Ward's "Faith and Freedom," sums up the fact most of us have realized: this, for good or ill, is "one world."

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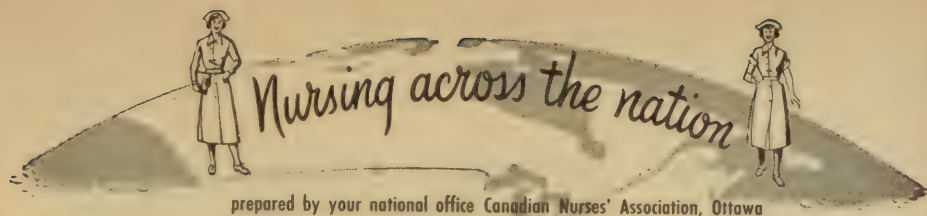
1. Rosenberg, S. and Oster, K. A., "Gelatine in the Treatment of Brittle Nails," *Conn. State Med. J.* **19**:171-179, March 1955.

2. Tyson, T. L., *J. Invest. Dermat.* **14**:323, May 1950.

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## *That the People be Served*

In another part of this issue you will read the excellent address presented by Miss Dorothy Percy, at the 28th Biennial Meeting, entitled "Signpost at Geneva." This will bring to your mind very vividly the Technical Discussions of WHO held in Geneva last May.

We should like to quote here from the summary presented by Mrs. Lucille Petry Leone, Department of Health, Education and Welfare, at the final plenary session.

This is the first time, on an international basis, that outstanding doctors and health administrators have met with nurses to consider together problems of nursing. This is an historic occasion; but, more important is the practical value it will have for progress in health.

All who have participated in these technical discussions recognize the importance of nursing in bringing health to people and through health, raising the standard of living and freeing the human spirit for its fullest self-realization and creativity.

Of all the health professions nursing is perhaps the closest to people — closest to the largest number of people.

It is this closeness which calls for depth of personal understanding, tenderness, sympathy, and constructive personal and community attitudes. The people to whom we nurses are close are of all ages, from birth to old age. They have varied social and economic backgrounds. They exhibit all degrees of health from that robustness we strive to maintain, to suffering from all the scourges man is heir to which we nurses under medical direction, strive to relieve. We are close to people in their homes, in health centres, in hospitals, in the workshop; to children in schools; to people as they work together for health in community groups.

Here, in this closeness, lies the justi-

fication for our learning principles of social sciences to apply in human relationships.

As the definition of health is broadened and as modern science advances the responsibilities of nursing, like those of medicine and public health expand.

If we speak of improving the education or training of the nurse it is for this reason; that nurses may be able, after that training, to meet their expanding responsibilities. If we say that the young men and women who want to be nurses should have reached a higher stage of education before entering training for the profession, it is because the nature of nursing requires its practitioners to be wise in many ways and its students to have foundations on which the learning of nursing can be based.

If we speak of the independence of nursing education from hospital control it is because we believe that in this way nurses can be better prepared for their total responsibilities in all kinds of hospitals and in community nursing.

When we speak of improved preparation of nurse teachers it is for the sake of improving the practice of nursing as it touches people.

When we speak of legislation to control the practice of nursing and the licensure of various types of nursing personnel, we are speaking of protecting the public from unsafe practices.

When we speak of preparing nurses for administration and placing them in administrative positions in nursing schools, hospitals, public health agencies and in national health administrations it is for the sake of improving nursing services for people.

These are some of the ways in which nursing services can be improved.


Population grows rapidly and the services to be rendered grow even more rapidly. And so we need more nurses everywhere.

All that is done to improve nursing education will serve also to attract more



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**antepartum:** For nipple conditioning  
**postpartum:** For prevention and treatment  
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students and make nursing a more attractive career in the minds of their parents. Stimulating teaching; variety of learning experiences inside and outside hospitals; the satisfaction of applying scientific principles in the care of people, sick and well; improving living, social, and recreational facilities for students; and the mutual respect among the members of the health professions. These will attract students. Recognition of nursing education as meriting independent support as does education for the other professions will attract discerning young people and their parents as they face career choice. So, also, will recognition of nursing as a field in which workers may advance to teaching and administrative positions increase its attractiveness.

We desire to be cooperative team members and, as our competence develops, to be members of the administrative team. We see nursing organically related to the total health effort. All our striving, even at these technical discussions, has one aim — that the people be served.

### *F.N.I.F. Conference*

The Florence Nightingale International Foundation has announced a conference to be held on "Planning of Nursing Studies." The member countries of the International Council of Nurses are invited to send two delegates. To date, the national nurses' associations of 22 countries have indicated their wish to participate. The CNA Executive Committee has approved the attendance of Miss F. Lillian Campion, Nursing Service secretary and Miss Rita MacIsaac, assistant secretary at this conference which is to be held in Sèvres, France, November 12 to 24, 1956. Miss Margaret Arnstein, Chief, Division of Nursing Resources, Department of Health, Education and Welfare, Public Health Service, Washington, will be the conference leader.

It is anticipated that not only will the participants gain knowledge of the techniques and procedures for planning studies, but as the representatives from 22 national nurses' associations study and work together, a greater understanding of each other's problems will result.

### *Committees Have New Chairmen*

Under the revised By-Laws of 1954, CNA national committee chairmen are appointed by the Executive Committee at the beginning of each biennium. So far those who have consented to act are Miss Alice Girard, chairman of the Committee on Finance, Miss Helen Carpenter, chairman of the Committee on Legislation and By-Laws, Miss Katherine MacLaggan, chairman of the Committee on Nursing Education and Miss Electa MacLennan, chairman of the Committee on Nursing Service.

Miss MacLaggan is new to the CNA Executive Committee but as chairman of the Committee on Nursing Education of the New Brunswick Association of Registered Nurses, was a member of the national committee from 1954-1956. New Brunswick is vitally interested in nursing education, having at present, a research study being carried out by Miss E. Kathleen Russell.

As Director, School of Nursing, Dalhousie University, Halifax, Miss MacLennan is actively engaged in the promotion of improved nursing service as indicated by the excellent institutes held yearly at that school under her direction.

We are confident that these four national committees will fulfil their functions under such capable leadership.

### *ICN Committee on Nursing Service*

We have reported previously on the activities of the ICN Committee on Nursing Service in preparing papers on acceptance standards of various aspects of nursing service. The July issue of the *ICN Monthly Newsletter* reports that two of these papers have been made available. The paper on neurosurgical nursing, prepared in collaboration with the Swedish Nurses' Association, can be obtained in pamphlet form from the International Council of Nurses, 1, Dean Trench Street, Westminster, London S.W.1, England. The cost is one shilling plus mailing costs.

The paper on occupational health prepared in collaboration with the National Council of Nurses of Great Britain and Northern Ireland was




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published in the May issue of the *International Review*, the official organ of the International Council of Nurses.

### *New Publications*

Health insurance is a matter which should be of concern to all nurses, both professionally and personally. Two publications have recently been received which will be helpful in understanding the issues involved: (1) *The Administration of Health Insurance in Canada* — by Malcolm G. Taylor, published by the Oxford University Press, Toronto, \$5.00; (2) *Health Insurance* — a pamphlet prepared by the Canadian Welfare Council, Ottawa, \$1.00.

### *Films on Rehabilitation*

Nurses are becoming increasingly aware of the importance of rehabilitation in all aspects of nursing.

The Civilian Rehabilitation Branch of the Department of Labor, Ottawa, has prepared a list of films dealing with various aspects of rehabilitation. The films are classified according to their main content such as rehabilitation centres, welfare, crippled children, medical and surgical, etc. They are listed in two parts: (1) Those films available from Canadian organizations, local libraries and the Canadian Film Institute; and (2) films available from the United States. In addition, a short description of the film is given together with running time, producer and listing.

Schools of nursing and health agencies planning in-service educational programs will find this pamphlet very helpful. It may be obtained from Mr. Ian Campbell, National Coordinator, Civilian Rehabilitation Branch, Department of Labor, Ottawa.

## *Le Nursing à travers le pays*

### *Servir le Public*

Dans une autre partie de cette édition, vous pourrez lire l'excellente allocution faite par Mlle Dorothy Percy, au 28ième Congrès biennal, intitulée "Signpost at Geneva." Cela vous rappellera très clairement les délibérations techniques de l'OMS qui eurent lieu à Genève, en mai dernier.

Nous désirons rapporter ici des paroles prononcées par Mlle Lucille Petry Leone, du Ministère de la Santé et de l'Education des Etats-Unis au cours de ces assises:

"Pour la première fois, à l'échelle internationale, des médecins éminents et des administrateurs de services de santé se sont réunis pour discuter avec des infirmières des problèmes du nursing. C'est un événement historique, peut-être, mais aussi un événement qui aura une répercussion des plus heureuses sur le progrès en matière de santé.

"Tous ceux qui ont pris part à ces délibérations techniques reconnaissent l'importance du nursing dans la protection de la santé publique. La santé amène une élévation du niveau de vie, libère l'esprit, favorisant ainsi la création et la réalisation des oeuvres.

"De toutes les professions ayant trait à la santé, le nursing est peut-être celle qui se penche le plus sur le peuple — elle est le plus prêt du plus grand nombre.

"Ce contact avec l'humanité demande une compréhension profonde de l'individu, de la sympathie et une attitude d'encouragement envers tous et chacun. Le peuple duquel nous nous rapprochons, nous, infirmières, comprend des personnes de tous les âges, du berceau à l'âge mûr et d'un niveau social et économique très varié. Ils possèdent la santé à divers degrés et c'est notre devoir de protéger celle des plus robustes et de venir en aide au plus faible, au moyen de conseils et d'enseignements sur la santé. Nous avons l'occasion de nous pencher sur le peuple quand nous visitons les foyers, dans nos centres d'hygiène, à l'hôpital, à l'usine, à l'école.

"L'occasion nous est constamment fournie d'appliquer dans les relations humaines les principes que nous avons eu l'avantage d'acquérir dans l'étude des sciences sociales.

"Comme le sens du mot santé s'élargit constamment et que la science fait sans cesse des progrès, les responsabilités du



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nursing et de la médecine comme de l'hygiène publique sont toujours en s'accroissant.

"Pourquoi parle-t-on sans cesse d'amélioration de la formation de l'infirmière? C'est pour qu'elle soit en mesure de s'acquitter de toutes ces responsabilités. Si nous affirmons que les jeunes filles et les jeunes gens qui se destinent à la profession du nursing doivent posséder une solide éducation avant d'entrer à l'école de nursing, c'est parce que le nursing, par sa nature, exige de ceux qui le pratiquent des connaissances étendues et approfondies et par conséquent, les étudiantes en nursing doivent posséder une base solide sur laquelle sont édifiés les principes et l'art du nursing.

"Si nous parlons de l'indépendance du programme de l'enseignement du nursing du contrôle de l'hôpital, c'est parce que nous croyons que de cette façon les infirmières seraient mieux préparées pour les responsabilités multiples qu'elles devront assumer dans les différents genres d'hôpitaux et dans la collectivité.

"Lorsque nous parlons de perfectionnement dans la préparation des éducatrices en nursing, c'est dans le but unique de pouvoir prodiguer au public des soins meilleurs et un enseignement plus profitable en matière de santé.

"Lorsqu'il est question de législation pour contrôler l'exercice de la profession d'infirmière, et d'une licence ou permis d'exercer pour les différentes catégories de personnel en nursing, cela veut dire protection du public contre certaines pratiques dangereuses.

"Lorsque nous parlons de préparation d'infirmières pour occuper des fonctions administratives dans les écoles d'infirmières, les hôpitaux, les organisations d'hygiène publique et les services de santé du pays, c'est toujours dans le but d'améliorer le service du nursing dans la collectivité.

"Voilà donc des moyens qui peuvent concourir au perfectionnement du service du nursing.

"La population s'accroît rapidement et les services requis augmentent encore davantage. Partout, l'on a besoin des services de l'infirmière.

"Tout ce que l'on peut faire pour parfaire l'éducation en nursing servira aussi à attirer un plus grand nombre d'étudiants et à rendre plus attrayante la carrière d'infirmière dans l'esprit de leurs parents. Enseignement stimulant, variété de l'expérience à l'hôpital et en dehors de celui-ci, la satisfaction de pouvoir appliquer les principes scientifiques acquis, au soin des malades et à la protection de la santé des bien-portants, formes d'acti-

vité sociale susceptibles d'attirer et d'intéresser les étudiantes et le respect mutuel parmi les membres des professions. Voilà autant de facteurs qui contribueront à attirer des étudiantes à l'école d'infirmières. Lorsqu'on reconnaîtra que l'éducation en matière de nursing comme celle qui a trait à toute autre profession offre à ces éducatrices les moyens de gagner leur vie de façon très satisfaisantes, les jeunes filles éclairées et les parents avisés seront encore plus attirés vers la profession du nursing dans le choix d'une carrière. Il est donc important que la profession d'infirmière soit en mesure d'offrir un champ d'action au sein duquel les membres puissent aspirer à l'enseignement, à des fonctions administratives si l'on veut y attirer un plus grand nombre de candidates.

"Nous désirons faire partie de l'équipe du nursing et y travailler de notre mieux puis, si notre compétence nous le permet, devenir membres de l'équipe administrative. Nous envisageons le nursing organiquement lié à l'effort commun pour l'amélioration de la santé. Vers quoi tendent tous nos efforts, au cours de ces discussions d'ordre technique? Uniquement vers cet objectif: Servir le public."

### *Conférence de la Fondation Internationale Florence Nightingale*

La Fondation Internationale Florence Nightingale a annoncé une conférence sur "Planning of Nursing Studies." Les pays membres du Conseil International des Infirmières sont invités à y envoyer deux déléguées. Jusqu'à présent, les associations nationales d'infirmières de 22 pays ont exprimé le désir de participer à cette conférence. Le Comité Exécutif de l'A.I.C. a approuvé la présence de Mlle F. Lillian Campion, secrétaire du Service du Nursing et de Mlle Rita MacIsaac, secrétaire-adjointe, à cette conférence qui aura lieu à Sèvres, France, du 12 au 24 novembre 1956. Mlle Margaret Arnstein, Chef de la Section des Ressources du Nursing de la Division de l'Education et du Bien-Etre, Ministère de la Santé de Washington, sera chargée de la direction de la conférence.

L'on se rend compte que les personnes qui auront l'avantage de prendre part à ces importantes assises n'acquerront pas seulement des connaissances dans les techniques et procédés dans l'organisation des études mais que de plus, venant de 22 pays différents et travaillant ensemble, elles apprendront à connaître les problèmes qui se posent ailleurs ce qui, nul doute, favorisera une



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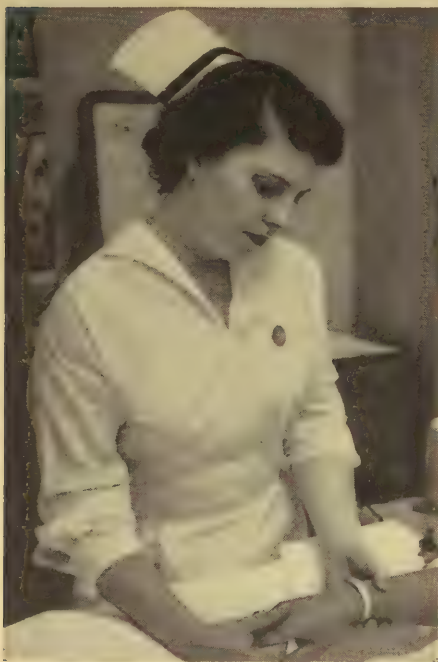
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## *Nomination des Présidentes de Comités*

Conformément aux Règlements modifiés en 1954, les présidentes des comités de l'A.I.C. sont nommées par le Comité Exécutif au début de chaque période biennale. Les personnes ayant accepté ces nominations, jusqu'à présent, sont Mlle Alice Girard, présidente du Comité des Finances, Mlle Helen Carpenter, présidente du Comité de la Loi et des Règlements, Mlle Katherine MacLaggan, présidente du Comité de l'Education en Nursing et Mlle Electa MacLennan, présidente du Comité du Service d'Infirmières.

Mlle MacLaggan est nouvelle dans l'Exécutif de l'A.I.C. mais comme présidente du Comité de l'Education en Nursing de l'Association des Infirmières enregistrées du Nouveau-Brunswick, elle fut membre du comité national de 1954 à 1956. La province du Nouveau-Brunswick est vivement intéressée dans l'éducation en nursing, poursuivant actuellement une étude de recherches sous la direction de Mlle E. Kathleen Russell.

Comme directrice de l'Ecole d'Infirmières de l'Université de Dalhousie, Halifax, Mlle MacLennan s'intéresse activement à l'amélioration du service du nursing comme en font foi les excellentes conférences organisées chaque année, sous sa direction, à cette école.

Nous sommes assurées que ces quatre comités nationaux rempliront, sous cette habile direction, leurs fonctions avec efficacité.

## *Comité du Service d'Infirmières du Conseil International des Infirmières*

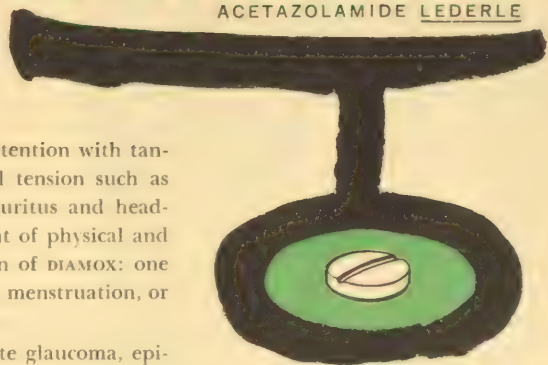
Nous avons déjà publié des articles sur les activités du Comité du Service d'Infirmières du Conseil International des Infirmières consistant dans la préparation de travaux portant sur les standards acceptables dans certains domaines du Service d'Infirmières. Le numéro de juillet du bulletin mensuel du Conseil International nous fait part que deux de ces brochures sont disponibles: l'une sur les soins en neuro-chirurgie, préparée en collaboration avec l'Association des Infirmières de Suède peut être obtenue en s'adressant au Conseil International des Infirmières, 1, Dean Trench Street, Westminster, London, S.W.1, Eng-

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1. Krantz, J. C. and Carr, C. J.: The Pharmacologic Principles of Medical Practice, Ed. 3. The Williams & Wilkins Co., Baltimore, 1954, p. 1014.

2. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, Ed. 2. The Macmillan Co., New York, 1955, p. 856.

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land, au prix de 1 shilling plus les frais de postes. L'autre sur la thérapie d'occupation, préparée en collaboration avec le Conseil National des Infirmières de Grande-Bretagne et de l'Irlande du Nord, fut publiée dans l'édition de mai de la *Revue Internationale*, organe officiel du Conseil International des Infirmières.

#### *Films sur la Réhabilitation*

Les infirmières se rendent de plus en plus compte de l'importance de la réhabilitation dans le nursing sous tous ses aspects.

La Section de la Réhabilitation Civile du Ministère du Travail, Ottawa, a préparé une liste de films traitant des divers aspects de la réhabilitation. Les films sont classifiés d'après le sujet dont ils traitent soit : centres de réhabilitation, bien-être, enfants infirmes, médecine et chirurgie, etc. Ils se divisent en deux catégories : (1) Les films que l'on peut obtenir d'organisations canadiennes, librairies locales et de l'Institut Canadien du Film; et (2) ceux que l'on peut se procurer aux Etats-Unis. On donne aussi une courte description de chaque film, sa durée, le nom du producteur, etc.

Les écoles d'infirmières et les organisations d'hygiène publique qui désirent établir un programme éducatif au sein de leurs institutions, trouveront ces petites brochures descriptives très utiles. On peut les obtenir en s'adressant à Mr. Ian Campbell, National Coordinator, Section de la Réhabilitation Civile, Ministère du Travail, Ottawa.

#### *Nouvelles publications*

L'assurance santé est une question qui devrait intéresser toutes les infirmières, professionnellement et personnellement. Deux brochures intéressantes ont été publiées à ce sujet : (1) *The Administration of Health Insurance in Canada* — par Malcolm G. Taylor, publié par Oxford University Press, Toronto, \$5.00; (2) *Health Insurance* — brochure préparée par le Conseil Canadien du Bien-Etre, Ottawa, \$1.00.

\* \* \*

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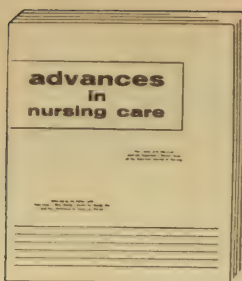
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The next 12 issues of the American Journal of Nursing will bring its subscribers more than 600 original articles on developments in all areas of nursing including 40 illustrated reports of the latest advances in bedside care.

If you are not already scheduled to receive the Journal every month, we invite the immediate fill in and return of the convenient order form below. It will bring you, in addition to 12 issues of nursing's most useful publication, a complimentary copy of the just-off-the-press 88 page "Advances in Nursing Care," a 135-report summary of needful-to-know data, including a particularly valuable group of new methods in the care of cardiovascular patients.

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## Sélection

*Conseils à une étudiante devant faire un stage à la salle d'Opération.*

Les portes de la salle d'opération s'ouvrent devant l'imposante civière, portant son fardeau si mystérieux, si inconnu dans sa vie et dans son âme: le malade.

Pourquoi ses yeux s'ouvrent-ils si grands? Pourquoi cherche-t-il la main amie? Le décor est donc si frappant? Remarque ces grands murs faïencés, dénudés de tout, d'où émerge le simple crucifix dans tout son abandon! Vois cette gigantesque lampe; cette table compliquée de leviers et de pédales; tous ces instruments étalés là, prêts à servir; ce silence lourd de choses qu'il ne comprend pas; cette minutie aseptique; toutes ces personnes vêtues de blanc, les mains gantées, le visage voilé... Toi, infirmière avertie, ne comprendras-tu pas le tremblement des lèvres, une larme, la surexcitation ou le calme, le mutisme frappant de ce malade qui voit toutes ces choses s'ordonner et se perfectionner en vue de lui, de sa néphrec-

tomie ou de son appendicectomie. Il est là, attaché à une table, lui un vivant, livré aux chirurgiens. Un moment encore et sa sensibilité sera étouffée par les anesthésiques, son intelligence enténébrée. Il ne pensera plus que par l'intelligence, il ne vivra plus que par la conscience des médecins et des infirmières qui l'entourent. Sauras-tu calmer un peu ses appréhensions?

Oui, si tu sais, dès l'arrivée du patient, le saluer gentiment, lui montrer un intérêt sympathique et le transférer sans heurt sur la table. Parfois, il te dira ses craintes, sa peur; ou bien souvent, il ne soufflera mot. Tu peux, par des paroles adroites, discrètes, déceler assez clairement sur quoi porte sa crainte. Est-ce l'anesthésie? Est-ce l'intervention chirurgicale? Sont-ce les suites de l'opération? Peut-être est-il alarmé par le spectacle de l'outillage ou de l'instrumentation!

Rassure-le par un sourire, un bon mot. Que tes gestes nécessaires à la préparation de l'opération soient faits avec calme et sûreté, surtout sans précipitation. Tu es capable de lui insuffler ces grands sentiments de confiance et de courage parce que tu dois les porter en toi. Surtout, ne va pas paraître indifférente ou trop habituée à ce qui va se passer. Ou bien, ne te laisse pas emporter par la gravité de l'heure en oubliant le patient et en te livrant entièrement aux préparatifs.

Es-tu certaine qu'il a, comme toi, pleinement confiance au chirurgien et à l'anesthésiste? Suggère-le-lui en glissant un éloge discret de ceux-ci: "Votre médecin est tellement compétent et a fait preuve de si grands succès passés. Et vous ne voyez pas l'anesthésiste, toujours aux aguets devant la moindre réaction de votre pouls, votre respiration, votre tension artérielle?"

Tous ces bons mots, tous ces sourires rassemblés n'apportent-ils pas un peu de sérénité dans cette âme inquiète?

Puis l'immobilisation d'un membre, une certaine position plus ou moins agréable sont parfois nécessaires même avant la perte de conscience du malade. Il est facile pour toi de lui expliquer les motifs de cette immobilisation en prenant bien soin de ne pas découvrir le malade inutilement.

L'opération retarde . . . Laisseras-tu le malade seul avec son imagination vagabonde, errer dans le pays de la peur, des idées noires et des appréhensions? Demeure avec lui. Sache l'entretenir aimablement.

Je disais auparavant de faire l'éloge bien mérité des maîtres de la chirurgie et de l'anesthésie. Oui, bien sûr, mais au-dessus de tout cela, il y a le Maître suprême, divin, qui prend soin des petits oiseaux, qui peut tout et à Qui nous devons tout. Confie-lui la confiance que tu as envers ce grand Dieu d'Amour. Dis-lui comment son cœur est immense, comment Il peut apporter la paix et la résignation. S'il se sent incapable de prier, fais-le pour lui. N'oublie jamais que c'est Lui le grand commandant et que les médecins et infirmières doivent tendre leur volonté, leur esprit pour le plus grand bien du malade.

Un grand chirurgien disait: "Surtout, ne nous pressons pas, nous n'avons pas de temps à perdre."

Marie Lupien, étudiante-infirmière  
2ième année, Extrait du Bulletin *Sous  
le Voile* de l'Ecole Jeanne Mance, Hôtel-  
Dieu d'Arthabaska. 1956.

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What should a baby be doing at various ages? Emphasizing first of all that there is no absolute criterion and that each baby is a law unto himself, here are some rough standards published in the Journal of the Michigan State Medical Society:

At 1 month he regards you without apparent comprehension.

At 2 months he smiles, maybe at you maybe not.

At 3 months he turns his head.

At 4 months he holds his head up.

At 5 months he rolls over.

At 6 months he transfers objects from hand-to-hand, dropping many.

At 7 months he sits up briefly, but rolls over easily.

At 8 months he creeps — and then look out.

At 9 months he pulls himself up, often pulling things over on him.

At 10 months he cruises, maybe on all fours.

At 11 months he walks with support.

Remember again that your baby has no absolute standards except what he chooses to do. You cannot hurry him or retard him much, no matter what you do.

\* \* \*

Many doctors believe that high blood pressure is more common today because more people do their work at desks or benches and get little exercise. An English study shows that high blood pressure occurs more frequently among bus drivers who are seated all day than among conductors who are constantly running up and down the stairs of London's two-decker buses.

## In Memoriam

(Continued from page 808)

died on May 23, 1956 at Monroe, Mich.

\* \* \*

**Isobel (Robertson) Portland**, who graduated from Toronto General Hospital in 1936 died at Collingwood, Ont. in June, 1956.

\* \* \*

**Charlotte Tuck**, who graduated from the Mack Training School, St. Catharines General Hospital in 1905, died there on June 13, 1956 in her 82nd year. Miss Tuck had followed the profession she loved for 50 years, having retired only a couple of years ago.

\* \* \*

**Irene (Follett) Warwick**, who graduated from Toronto General Hospital in 1929, died at Toronto on June 16, 1956. In tribute to her memory, her classmates sent a donation to the Cancer Society.

**SMOKE**

**Player's**  
"MILD"



**THE  
MILDEST  
BEST-TASTING  
CIGARETTE**

## In the Good Old Days

(*The Canadian Nurse* — OCTOBER, 1916)

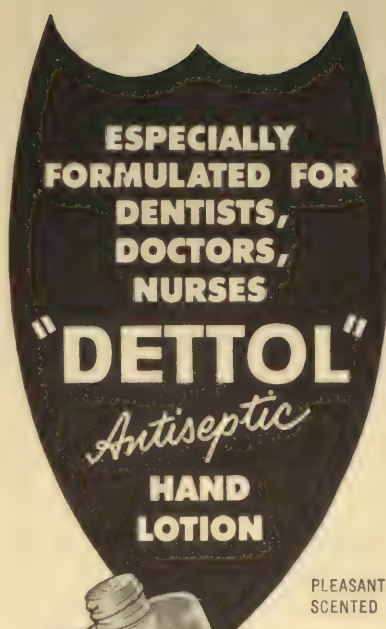
Blessed is the school of nursing that can select from the attending doctors a corps who have the requisite teaching ability to instruct pupil nurses adequately . . . To get a class of pupil nurses to use their brains in the formation of principles and then the application of these principles to new cases is an achievement of far greater value than the acquiring of a few facts . . . The question that the doctor has to decide is how much shall be taught. Too often he wades bravely ahead only to find at examination time his students have been overwhelmed by the great billows of learning . . . It is much better to lay well the foundation of principles, leaving most of the detail to ward instruction. The effect of the doctor's teaching would be much increased if there could be a nurse as ward instructor who would emphasize at the bedside the details in nursing coincident with the subject taken up by the lecturer.

\* \* \*

Why is interest in postgraduate education for nurses developing to such an extent? The first thought is that this is an age of specialization. Different nursing activities, such as public health, call for skills that cannot be provided in the regular course in the hospital . . . The bigger problem is presented by nurses who realize they have been inadequately taught in their own school. When we stop to consider the lack of uniformity in curriculum, the differences in the teaching provided and in the whole tone and atmosphere of some schools, can we wonder that a class of postgraduate students requires skilful handling if they are really to benefit by their additional experience? Moreover, there is often a disturbing question of discipline!

\* \* \*

We have grown in recent years, sometimes to forget that we are nursing the patient and not the disease. Pupil nurses are apt to be most interested in that part of the science of medicine and surgery which least concerns them. The average nurse thinks she is doing much more important work when caring for a postoperative or a fracture patient than when she is caring for a case of disintegrating carcinoma or a paralytic. She changes the dressings on a wound without a murmur but hates to be on a children's



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ward where she is "always changing babies." Most nurses are much more enthusiastic over what the surgeon does in the operating room than what the dietitian is doing in the kitchen!

\* \* \*

Having all the nursing care given by graduates has been found unsatisfactory because it is difficult to secure a sufficient number, without resorting to the nurse who has somehow or other lost her diploma but always comes from Guy's in London.

## For the Man of the Future

If present trends are any indication, the man of the future may be able to have any part of his malfunctioning circulatory system removed and replaced — possibly by synthetics.

At the turn of the century, a German surgeon reported that he had successfully transplanted arterial homografts in dogs but for many years the work advanced no further. Then, in 1949, a method of preserving the viability of grafts until they were needed for transplantation was found. Arterial grafts became something of a practicality. Soon preservation methods were sufficiently developed to permit a Blood Vessel Bank to be opened in New York City. The success of this bank and the proven value of artery transplants in restoring normal blood flow to vital organs in arteriosclerosis, saving limbs after severe accidental injury, replacement of aneurysms and cancerous vessels and substitution for congenitally missing vessels is evident. Now it is hoped that very soon surgeons may be able to operate following a heart attack and either remove the arterial obstruction or take the artery out and replace it. A method is needed to pinpoint the site of obstruction but it is felt that this obstacle will shortly be overcome.

Human arterial grafts are scarce. Even with permanent storage such as is now possible with deep-freezing and freeze-drying, the essential difficulty of procuring grafts remains. Animal studies suggesting that closely woven cloth of some of the synthetic fibres would permit autogenesis of arterial coats of fibrous tissue was a triumph over this difficulty. Recently both British and American workers have reported that plastic implants composed of orlon, dacron, nylon or Vinyon-N have been used successfully in humans. Research is continuing in order to find the most suitable synthetic arterial



grafts. Some of the problems already seem to be solved. By using a braided nylon which can be made wrinkleproof and waterproof, troublesome seams and ragged edges are avoided, the fabric remains permeable to fibroplastic penetration and there is sufficient flexibility to permit grafting across the line of flexion of a joint.

To our Number 1 health problem today, the surgeon is bringing the most concrete hope of cure of any of the specialists. They have raised the question of the year. Can they retread an individual's vascular network, much like you can tires, and save thousands from chronic cardiovascular deaths?

— COMMUNICATIONS ASSOCIATES, INC.

\* \* \*

When I'm getting ready to reason with a man, I spend one third of my time thinking about myself and what I am going to say — and two thirds of my time about him and what he is going to say.

— ABRAHAM LINCOLN

## Victorian Order of Nurses

The following are staff changes in the Victorian Order of Nurses for Canada:

**Appointments** — Burnaby: *Mrs. Mary McIntosh* (Misericordia Hosp., Winnipeg). Calgary: *Treva Tingley* (Victoria Gen. Hosp., Halifax). Edmonton: *Mrs. Jean Howe* (U. of Alta S. of N.). Hamilton: *Frances Lee* (Ham. Gen. Hosp.); *Mary Schaffter* (Gen. Hosp., Birkenhead, Eng.). Lachine: *Monique Gregoire* (Hôpital St. Luc, Quebec). Lincoln-St. Catharines: *Mrs. Luella Springham* (Hackley Hosp., Michigan). London: *Roberta Scanlon* (Victoria Hosp., London). Medicine Hat: *Elizabeth Taylor* (Calgary Gen. Hosp.). Montreal: *Sylvia Evans* (St. Mary's Hosp., Montreal); *Jean Grant* (Charlottetown Hosp.). Ottawa: *Shirley Cameron* (Univ. of Ottawa). Owen Sound: *Kathleen Eby* (Kitchener-Waterloo Hosp.). Peterborough: *Mrs. Anne Campbell* (Royal Infirmary, Edinburgh). Saskatoon: *Jennie Victor* (St. Paul's Hosp., Saskatoon). Toronto: *Elizabeth Bugar* (Toronto Gen. Hosp.); *Phyllis Dawson* (Toronto West. Hosp.); *Lois Dedrick* (Toronto West. Hosp.); *Mrs. Helen Heenery* (McMaster Univ. S. of N.); *Katherine MacDonald* (St. Jos. Hosp., Toronto); *Betty Robbins* (Wellesley Hosp.); *Elaine Shenson* (Univ. of Toronto); *Eileen Warren* (Toronto West. Hosp.); *Mrs. Mary Watson* (U. of T.):



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Veganin helps to bring swift relief at specially difficult times, or at any time pain strikes . . . helps to calm jittery nerves without producing a feeling of drowsiness or stomach upset. For "Stronger" relief, it's Veganin too, with approximately 8 grains of anti-pain medication.

Once you've tried Veganin you'll know why so many Doctors prescribe it for their patients. Available in tubes of 10's and 20's.



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*Mary Weiler* (St. Jos. Hosp., Toronto); *Monna Zentler* (Metropolitan Hosp., London, Eng.). Vancouver: *Mrs. Joyce MacRae* (Vancouver Gen. Hosp.); *Clarisse Maes* (St. Boniface Hosp.); *Jocelyn Money* (Vancouver Gen. Hosp.); *Mrs. Rosemary Pulfer* (St. Paul's Hosp., Vancouver). Victoria: *Mrs. Jacoba Campbell-Hope* (Royal Alex., Edmonton). Windsor: *Gwyneth Edmunds* (Toronto West. Hosp.). Winnipeg: *Shirley Karlossky* (Winnipeg Gen. Hosp.); *Mrs. Elva Redston* (W.G.H.); *Blanche Schentag* (Misericordia Hosp., Winnipeg). Woodstock: *Alilian Whyte* (St. Olave's Hosp., London, Eng.).

**Transfers** — Frances Cook from Truro to Ottawa. *Leolla Brintnell* from York Township to nurse in charge Weston. *Freida Hug* from Toronto to London staff. *Mrs. Julia Gabris* from Sackville to nurse in charge Truro. *Mrs. Dorothy Mathieson* from Victoria to Vancouver staff. *Lorraine Miller* from National Office to nurse in charge Saskatoon. *Mrs. Shirley Sinms* from Toronto to North York staff. *Maureen Southcott* from Toronto to Corner Brook staff. *Muriel Stevens* from Toronto to North York staff. *Mrs. Venetta Vyse* from Toronto to Burlington staff. *Janet Zinck* from Toronto to London staff.

## SAGUENAY GENERAL HOSPITAL ARVIDA, QUEBEC

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Graduate nurses for general duty registered in the Province of Quebec. Regular employment. Room, board & laundry service of uniforms provided. Very favorable working & living conditions. Starting salary commensurate with qualifications & experience. For further information please write stating qualifications & experience to:

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LIMITED**

c/o Miss L. Mackenzie

1700 Sun Life Building, Montreal, Que.

## News Notes

### BRITISH COLUMBIA

#### CHILLIWACK

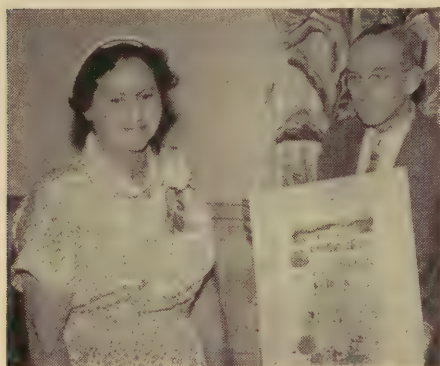
I. Barwell, regional president of the Lower Fraser Valley, presided at the recent regional meeting. Thirty-two members representing Abbotsford, New Westminster and the local chapter were in attendance. Miss Barwell gave a colorful report of the Biennial Convention, praising those responsible for planning enthusiastically. Miss Deacon, a student from the Royal Columbian Hospital reported on "Student's Day." A short program concluded the meeting.

#### COMOX

Dr. H. A. Mooney addressed a meeting of the district members late in June. His subject, "Golden Staphylococcus Infections" was of vital interest to his listeners since it has produced so many medical and nursing problems. Mrs. Dickie from the Duncan chapter and Mrs. Jones of Victoria gave reports on the annual provincial convention. K. Baillie attended the Biennial Convention in Winnipeg representing the district. The next meeting is to be held in Ladysmith late in October.

## PENTICTON

The profession of nursing, and in particular the public health branch, reflected the honor bestowed upon Miss Joan Appleton when she was accorded the Freedom of the City during a recent ceremony. In this way a grateful people acknowledged warmly the devoted services of an outstanding public health nurse, not only in line of duty but in community and church activities as well. Her departure for Chilliwack where she will assume similar responsibilities was cause for sincere regret.



*Joan Appleton receives the Freedom of the City*

A graduate of St. Thomas Hospital, London Miss Appleton entered the public health field following postgraduate study. During the war years she engaged in civil defence work eventually joining U.N.R.R.A. where her specific duties centred around the care of refugees and displaced persons. In 1947 she joined the B.C. Health Services serving at various times in Ashcroft and Summerland before coming to Penticton in 1950.

## QUEBEC

### QUEBEC CITY

#### *Jeffrey Hale's Hospital*

Dr. D. Gendron gave the address to the graduating class at the alumnae dinner held early this year. Members of the class who received special awards were Mrs. E. Hamel, Board of Governors award for general proficiency and the Dr. J. S. Gregory award in gynecological nursing; J. Richardson, the Margaret Teakle award for bedside nursing; V. Smith, the Women's Auxiliary award for surgical nursing and the alumnae award for showing greatest improvement during the course of training. Each member of the class received a copy of a nurse's quick reference manual as a gift from the medical staff. This year's graduation exercises had special significance for the Richardson family since Janice Richardson was the fifth of five sisters to complete her training at this hospital.

Mrs. J. Green attended the Winnipeg convention as an official delegate from the province.

## Calling All Canadian Graduate Nurses

### • How would you like to work and live in the heart of Manhattan?

THE ROOSEVELT HOSPITAL, a voluntary, general hospital, offers you this opportunity.

### • Why not enjoy these benefits offered by Roosevelt?

**BASE SALARY** — Begins at \$270 per month, without experience. Experience qualifies for higher starting salary.

**INCREMENTS** — Start after first 6 months and continue annually.

**BONUSES** — \$40 for evening and \$20 for night duty.

**VACATION** — 4 weeks annually.

**HOLIDAYS** — 10 annually.

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*For further information write to:*

**DIRECTOR OF NURSING,  
DEPARTMENT NS,  
ROOSEVELT HOSPITAL**

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New York City**



## GRADUATE COURSE IN EYE, EAR, NOSE AND THROAT NURSING

(Six Month Special Study)

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### PRACTICAL NURSES

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CASH'S: 3 Doz. \$1.89; 9 Doz. \$3.00; NO-SO NAMES: 6 Doz. \$2.49; 12 Doz. \$3.59; 25¢ per tube

In 1955, Canada's population was 15,573,000 with Ontario and Quebec, in that order, recording the highest figures provincially — 5,183,000 and 4,520,000 respectively. Alberta proved to be the "most marriageable" province with 9.2% of its inhabitants engaging in matrimony. Prince Edward Island showed the lowest marriage rate. Newfoundland recorded the highest percentage of births with Alberta a close second. Quebec, Saskatchewan and Alberta had the lowest death rates of the ten provinces, with equal standing of 7.5%.

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### ELMIRA PRIVATE HOSPITAL

Excellent opportunity for someone interested in operating an established business. Equipped throughout for sixteen (16) patients.

*For further information apply:*

**ELMIRA PRIVATE HOSPITAL, ELMIRA, ONTARIO**

# Employment Opportunities

ADVERTISING RATES — \$5.00 for 3 lines or less; \$1.00 for each additional line.  
U.S.A. & Foreign — \$7.50 for 3 lines or less; \$1.50 for each additional line.

Closing date for copy and cancellations: 10th of the month preceding the month of publication. All letters should be addressed to: The Canadian Nurse, 1522 Sherbrooke St. W., Montreal 25, Que.

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**Superintendent of Nurses (1).** Salary: \$275 per mo. **Graduate Nurses (2).** Salary: \$225 per mo. less \$40 per mo. room, board & laundry. 28-bed hospital, pleasant surroundings, 5 mi. from U.S. border. 40-hr. wk., 4 wk. vacation after 1 yr. service. 1½ days sick leave per mo., yearly accumulative. Nice nurses' residence. Apply The Grands Forks Community Hospital, Grand Forks, B.C.

---

**Matron (November 1st.) for 27-bed Community Hospital.** Salary: \$300 per mo. 40-hr. wk. 28 days vacation after 1 yr. service, all statutory holidays paid. Room, board & laundry \$40. Good knowledge of X-ray essential. Apply, giving full details to Sec., Slocan Community Hospital, New Denver, B.C.

---

**Superintendent of Nurses** for modern 80 bed hospital required immediately. Operating room Supervisor & Registered Nurses for general duty. Good personnel policies and salary for fully qualified nurses. Apply, stating qualifications and experience, to Administrator, Portage Hospital District No. 18, Portage La Prairie, Man.

---

**Superintendent of Nurses for 53-bed hospital.** Fully accredited & offering ideal working conditions to a qualified Registered Nurse. Salary: \$225 plus full maintenance & apt. in new nurses' residence. Excellent personnel policies. 1 mo. annual vacation. Apply Secretary, Kentville Hospital Assoc., Kentville, Nova Scotia.

---

**Matron for modern 8-bed hospital.** Salary: \$285 per mo., less \$30 for full maintenance. Apply stating experience to Sec.-Treas., Union Hospital, Hodgeville, Saskatchewan.

---

**Matron (1) \$230 per mo. General Duty Nurses (2), \$200 per mo., with full maintenance for 20-bed hospital.** Modern nurses' home. Usual holidays with pay & sick leave, etc. Apply to Matron, Union Hospital, Vanguard, Sask.

---

**Night Supervisor.** Salary: \$2,760-\$3,300 plus cost-of-living bonus approximating \$325 per annum. Excellent holiday, sick leave and pension benefits. Apply to Baker Memorial Sanatorium, Calgary, Alberta.

---

**Supervisor of Nursing Service for 50-bed active General Hospital.** Salary: \$210 plus maintenance with 6 monthly bonuses of 5%. 44-hr. wk. 10 statutory holidays & after 1 yr. on staff vacation of 21 days & sick time allowance of 14 days. For further information apply Miss M. Jarvis, Matron, Municipal Hospital Dist. #17, Wainright, Alta.

---

**Supervisor for Pediatrics Dept.** with postgraduate course or equivalent. Contract conforms with R.N.A.B.C. personnel practices. Apply Director of Nurses, General Hospital, Chilliwack, B.C.

---

**Supervisor of Nursing (R.N. experienced in nursing service administration desirable) for new modern 50-bed General Hospital** in progressive town (10,000) in Cariboo Dist. central B.C. 14 R.N.'s., 10 Aides, 6 Med. staff. Priv. suite in new residence. Salary commensurate with qualifications. 40-hr. wk., 28 days vacation plus 10 statutory holidays. Sick leave. Travel allowance. Please state age, salary expected, experience & references to Administrator, G. R. Baker Memorial Hospital, Quesnel, B.C.

---

**Operating Room Supervisor** for 110-bed hospital. Apply, Superintendent, Charlotte County Hospital, St. Stephen, N.B.

---

**Operating Room Supervisor and General Duty Nurses** for 43-bed General Hospital in friendly resort town. For further information, apply, Superintendent, District Memorial Hospital, Huntsville, Ontario.

---

**Supervisors & Staff Nurses.** Good salary & personnel policies. Living accommodations available. Apply Director of Nurses, General Hospital, Parry Sound, Ontario.

---

**Hospital Supervisor for 100-bed active General Hospital.** Rotating afternoon & night shift. Blue Cross. Statutory holidays. 4 wk. vacation & 2 wk. sick leave with pay after 1 yr. service. Accommodation in residence if desired. Apply stating experience & age to The Director of Nursing, Cottage Hospital, Pembroke, Ont.

---

**Night Supervisor, Assistant Head Nurses & Staff Nurses.** Excellent personnel policies. Apply Director, Shriner's Hospital for Crippled Children, 1529 Cedar Ave., Montreal, Que.



# An Opportunity for 50 NURSES in Hamilton, Ontario!



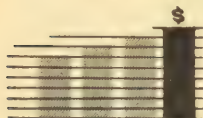
*The three city-owned hospitals, the General, the Mountain and the Nora-Frances Henderson, have recently undergone an expansion program and are in immediate need of a minimum of 50 Registered Nurses.*



Recognized as one of the most modern-equipped hospitals in Canada, the Hamilton General offers the Registered Nurse working and recreational facilities second to none.



Situated in the heart of what has been termed the "Golden Horseshoe", Hamilton is a city practically equidistant to Toronto and Buffalo, big enough to be interesting, yet small enough to be friendly and hospitable to the individual.



The rates of pay to Registered Nurses are the highest in the Province of Ontario. For Registered Nurses who work rotating hours of service, the beginning salary is \$53.00 per week. The daily rate is \$10.50 for each eight-hour period of duty.



Hours of duty: (a) 8 hour day—42 hours weekly average—rotating service. DAYS: 7 a.m. to 3.30 p.m. or 10 a.m. to 7 p.m.; EVENINGS: 3 p.m. to 11.30 p.m.; NIGHTS: 11.15 p.m. to 7.15 a.m. These schedules include one half hour for each meal and 15 minutes for morning coffee. (b) Two days off three successive weeks and one day off every fourth week. (c) All statutory holidays or compensatory time.



Vacations: Registered Nurses after one year of service receive 3 weeks vacation with pay. It is less than 200 miles to the beautiful Muskoka Lakes District, less than 2 hours to the U.S. border.

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Please send me more information concerning the opening for 50 nurses at your hospital. My address is:

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ADDRESS.....



# REGISTERED NURSES PROVINCIAL MENTAL HEALTH SERVICES of BRITISH COLUMBIA

Applications are invited for staff & administrative positions for Psychiatric & Tuberculosis units in the Essondale area, which is on the outskirts of Greater Vancouver. These positions have been created through re-organization & expansion of the Department of Nursing.

## Positions open:

**Supervisors:** for 225-bed Psychiatric & Tuberculosis unit. Postgraduate course in supervision or administration & postgraduate course in Psychiatric & Tuberculosis nursing or equivalent experience.  
**Salary: \$260 - \$315 per month.**

**Supervisors:** for Psychiatric units. Postgraduate course in supervision & psychiatric nursing or equivalent experience.  
**Salary: \$260 - \$315 per month.**

**Head Nurses:** for Medical Surgical Infirmary wards & Tuberculosis wards. Postgraduate course in psychiatric nursing or equivalent experience.  
**Salary: \$255 - \$287 per month.**

**Head Nurses:** for Mental Health Centre. Postgraduate course in Psychiatric Nursing or equivalent experience.  
**Salary: \$255 - \$287 per month.**

**Staff Nurses:** for Medical Surgical wards & Tuberculosis wards.  
**Salary: \$239 - \$271 per month.**

**Nursing Instructor:** for Training School.  
**Salary: \$255 - \$287 per month.**

40-hour week, statutory holidays, 4 weeks vacation with pay annually. Residence accommodation in modern residence \$5.00 per month, cafeteria meal service, 30¢ per meal. Recreational facilities. Applicants must be British Subjects & eligible for registration with Registered Nurses' Association of British Columbia.

Apply to:

THE PERSONNEL OFFICER,  
CIVIL SERVICE COMMISSION, ESSONDALE, BRITISH COLUMBIA.

**Evening Supervisors, Registered Nurses, Catherine Booth Graduates, Nursing Assistants for 68-bed hospital, 68 mi. from Montreal.** Excellent bus & train service. Salaries are in accordance with A.N.P.Q. Full maintenance. 8-hr. duty, rotating shift. 1½ days off per wk. 30 days annual vacation. Sick leave allowance. Blue Cross hospitalization paid by hospital. Apply Supt., Brome-Missisquoi Perkins Hospital, Sweetsburg, Que.

**Operating Room Supervisor for 118-bed General Hospital located in a beautiful residential suburb along the North Shore of Chicago.** Modern ranch style nurses' homes with attractively furnished private bedrooms. 40-hr. wk. Apply Director of Nursing Services, Highland Park Hospital Foundation, Highland Park, Illinois.

**Instructor for school of nursing** — Applications are invited for 138-bed hospital. This school is affiliated with Montreal hospitals, the teaching schools associated with McGill University. For particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

**Charge Nurse & Supervisory positions at Clearwater Lake Sanatorium, The Pas, Man.** Salary range: \$220-\$260 per mo. depending on qualifications & appointment. Board, room & laundry provided for \$39 per mo. in comfortable quarters. Generous vacation, group ins. all statutory holidays & other employee benefits. Apply Sanatorium Board of Manitoba, 668 Bannatyne Ave., Winnipeg, Man.

**Head Nurse capable of assuming more senior duties later.** Good salary & opportunities for the right person. Apply stating age & experience to The Queen Elizabeth Hospital, Toronto, Ont.

**Registered Nurses or Non-Registered Nurses if recent graduates (4) for very active 50-bed hospital.** Salary: \$180-\$185 depending on experience, plus complete maintenance & laundering of uniforms. \$5.00 increase every 6 mo. to a maximum of \$200 & 5% bonus every 6 mo. 88-hr. fortnight with rotating 8-hr. shifts. 10 statutory holidays & after 1 yr. on staff vacation of 21 days & sick time allowance of 14 days. For further information apply Miss M. Jarvis, Matron, Municipal Hospital District #17, Wainright, Alta.

**Registered General Duty Nurses (2) for 35-bed hospital.** Salary: \$185 per mo. plus full maintenance. 4 increments at \$5.00 per mo. after each 6 mo. 1 mo. vacation pay, sick leave & hospitalization benefits. If employed for 1 yr. a refund of train fare from any point in Canada given. Apply Miss M. A. MacDonald, Matron, Municipal Hospital, Two Hills, Alberta. Phone 335.

**Registered Nurses.** Single room residence. \$225 per mo. gross. 5 day wk. 20 mi. east of Toronto. Apply Supt. Ajax & Pickering General Hospital, Ajax, Ont.

**Registered Nurses.** Gross salary for nurses currently registered in Ont. \$235 per mo. Good personnel policies. New facilities. Comfortable nurses' residence. 8-hr. rotating shift. 44-hr. wk. 1 day off 1 wk., 2 the next. 1½ days holiday allowed per mo. same sick time accumulated to 90 days. 8 legal holidays per yr. The equivalent of single train fare paid up to \$40 after 1 yr. service. Apply Supt., Lady Minto Hospital, Cochrane, Ont.

**McKellar General Hospital, Fort William, Ont. requires Registered General Duty Nurses.** Good personnel policies. Residence accommodation available at reasonable rates. Hospital has recently completed a well equipped & staffed wing with extensive renovation program progressing in the old section. Apply Director of Nursing.

**Registered General Duty Nurses for 35-bed hospital.** Salary: \$250 less maintenance with increase after 6 mo. & yearly thereafter for 3 yrs. Apply Supt., Little Long Lac Hospital, Geraldton, Ontario.

**Registered Nurses for General Duty.** Initial salary: \$200 per mo.; with 6 or more months Psychiatric experience, \$210 per mo. Salary increase at end of 1 yr. 44-hr. wk.; 8 statutory holidays, annual vacation with pay. Living accommodation if desired. For further information apply Supt. of Nurses, Homewood Sanitarium, Guelph, Ont.

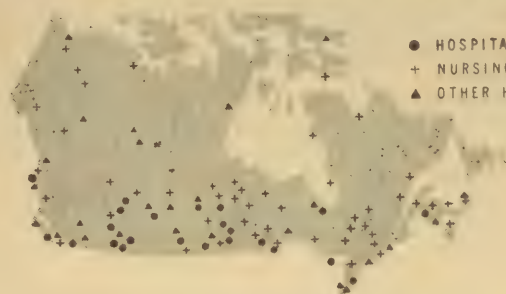
**Registered General Duty Nurses (3) for new modern 30-bed hospital.** New residence. Situated on Georgian Bay. Apply Superintendent of Nurses, General Hospital, Meaford, Ontario.

**Registered General Duty Nurses for 200-bed General Hospital.** Salary: \$220 per mo. 5½ day wk. Good personnel policies. Apply Director of Nursing, General Hospital, Sault Ste. Marie, Ontario.

**Registered General Duty Nurses for 200-bed hospital in the Niagara Peninsula.** Gross salary: \$215, afternoons — \$225, nights — \$220. Annual increments. 44-hr. wk. 3-wk. vacation per yr., 8 statutory holidays. Cumulative sick leave. Accommodation available in attractive residence. Apply Director of Nursing, County General Hospital, Welland, Ont.

**Reg'd. Nurses for modern 60-bed General Hospital situated 40 mi. south of Montreal.** Salary: \$200 per mo., additional monthly bonus for permanent evening & night shifts. 44-hr. wk., 8-hr. duty. Many attractive benefits provided. Board & accommodation available at minimum cost in completely new motel-style nurses' residence. Apply Supt., Barrie Memorial Hospital, Ormstown, Que.

# NURSING WITH INDIAN AND NORTHERN HEALTH SERVICES



- HOSPITALS
- + NURSING STATIONS
- ▲ OTHER HEALTH CENTRES

## OPPORTUNITIES FOR REGISTERED HOSPITAL NURSES, PUBLIC HEALTH NURSES, and NURSING ASSISTANTS or PRACTICAL NURSES

for Hospital Positions and Public Health Positions in Outpost Nursing Stations, Health Centres and Field Positions in the Provinces, Eastern Arctic and North-West Territories.

### SALARIES



- (1) Public Health Nursing Supervisors: up to \$4,620 depending on qualifications and location.
- (2) Directors of Nursing in Hospitals: up to \$4,620 depending on qualifications and location.
- (3) Public Health Staff Nurses: up to \$3,600 per year depending on qualifications and location.
- (4) Hospital Staff Nurses: up to \$3,420 per year depending upon qualifications and location.
- (5) Nursing Assistants or Practical Nurses: up to \$185 per month depending upon qualifications and location.

- Room and board in hospitals — \$30 per month. Statutory holidays. Three weeks' annual leave with pay. Generous sick leave credits. Hospital-medical and superannuation plans available.

- Special compensatory leave for those posted to isolated areas.

For interesting, challenging, satisfying work, apply to — Indian and Northern Health Services at one of the following addresses:

- (1) Regional Superintendent, 4824 Fraser Street, Vancouver 10, B.C.
- (2) Regional Superintendent, c/o Charles Camshell Indian Hospital, Edmonton, Alberta.
- (3) Regional Superintendent, 735 New Federal Building, Regina, Saskatchewan.
- (4) Regional Superintendent, 522 Dominion Public Building, Winnipeg 1, Manitoba.
- (5) Zone Supervisor of Nursing, Box 292, North Bay, Ontario.
- (6) Zone Supervisor of Nursing, P.O. Box 3427, St. Roch Branch, Quebec, Que.
- (7) Moose Factory Indian Hospital, Moose Factory, Ontario.

or

Chief, Personnel Division, Department of National Health and Welfare, Ottawa, Ontario.



**Registered General Duty Nurses (3) for 45-bed hospital in Southern Sask.** Salary: Min. \$225. Starting salary according to experience. Full maintenance \$30 per mo. 1 mo. vacation, statutory holidays, sick leave. Active town of 3,000 pop. Apply stating experience & when available to Supt., Union Hospital, Assiniboia, Sask.

**Registered General Duty Nurses (2) for Municipal Hospital 40 mi. NW of Saskatoon.** Excellent bus & train service. Salary range: \$225-\$255 per mo. Maintenance, \$30. Good personnel policies, 1 mo. vacation a yr. Apply E. M. Hillhouse, Sec.-Treas., Municipal Hospital, Borden, Sask.

**Registered Nurses (2) for modern 8-bed hospital.** Salary: \$240 per mo., less \$30 full maintenance. For further information apply B.E.L. Magnuson, Sec.-Treas., Union Hospital, Hodgeville, Saskatchewan.

**Registered Staff Nurses (Immediately) for 220-bed hospital, including new finely equipped wing.** Duty assignments in Obstetrical, Medical & Surgical Units. Gross starting salary: \$220. Good personnel policies. Paid vacations, sick leave, pension plan. Apply Director of Nursing Union Hospital, Moose Jaw, Sask.

**Registered Nurse (1) for 10-bed hospital.** Separate residence. Maintenance, \$18 per mo. Salary as per schedule plus \$5.00 increase per mo. 8-hr. shift. Usual holiday & sick leave. Apply Sec.-Treas., Union Hospital, Rabbit Lake, Saskatchewan.

**General Duty Registered or Graduate Nurses (2) for modern 20-bed hospital.** Salary: \$220 (Graduate), \$230 (R.N.). Increment of \$5.00 after each 6-mo. service. 1 mo. vacation with pay after 1 yr. service. \$30 per mo. maintenance. Separate staff residence. Apply Matron, Riverside Memorial Hospital, Turtleford, Sask.

**Registered Nurses. Male & Female.** Starting salary: \$300 up, plus \$10 pm shifts. 40-hr. wk., paid vacation, 10 days sick leave. Social Security, hospital group ins. Apply Mr. Glenn A. Dickau, R.N., Administrator, Memorial Hospital, Corning, California.

**Registered General Duty Nurses for 118-bed General Hospital** along the shores of Lake Michigan, 25 mi. from Chicago. Base salary: \$300. Additional differential of \$30 for evenings & \$20 for nights. 5 day wk. Good personnel policies. Apply Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

**Registered Nurses for Medical-Surgical, Psychiatric, Obstetrical & Pediatric Units, 325-bed, air-conditioned hospital.** Starting salary: \$265 with bonus for evening & night duty. 40-hr. wk. Liberal personnel policies, low cost cafeteria, free laundry. Apply Director of Nursing, Menorah Medical Center, 4949 Rockhill Rd., Kansas City, Missouri.

**Registered Nurses for 398-bed J.C.A.H. non-sectarian research & teaching hospital with N.L.N. fully accredited school of nursing.** Liberal personnel policies include tuition aid for study at Western Reserve University. Housing available at reasonable rates. Apply Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th St., Cleveland 6, Ohio.

**Registered Nurses for General Duty Staff.** Salary commences at \$40-10-0 per mo. with full maintenance. Transportation allowance. For full particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

**General Duty Nurses (3) immediately for 30-bed hospital.** Located in a good town 80 mi. east of Calgary on the CPR main line & the Trans Canada Highway. Salary: \$170 per mo. with full maintenance. Increase every 6 mo. 48-hr. wk. 8-hr. rotating shift. Apply by letter or wire for details of our staff plan to Mrs. H. Hislop, Matron, Municipal Hospital, Bassano, Alta.

**General Duty Nurses and Nursing Aides.** Active 700-bed general hospital. From September 1. Good working conditions. Personnel policies upon request. For further particulars apply to Director of Nurses, Royal Alexandra Hospital, Edmonton, Alta.

**General Duty Nurse for 17-bed hospital.** Starting salary: \$200 gross. 1 mo. vacation with pay after 1 yr. service. \$5.00 per mo. increase after each 6 mo. service up to 3 increases. Transportation refunded after 6 mo. service. Apply Municipal Hospital, Elnora, Alberta.

**General Duty Nurses.** Salary: \$230-270, \$10 increment for experience. 40-hr. wk. 1½ days sick leave per mo. cumulative; 10 statutory holidays, 1 mo. vacation. Must be eligible for B.C. registration. Apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

**General Duty Nurses for 430-bed hospital; 40-hr. wk. Statutory holidays.** Salary \$235-268. Credit for past experience. Annual increments; cumulative sick leave; 28 days annual vacation; B.C. registration required. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

**Supervisor,** starting salary: \$225. Must be registered in British Columbia. **Operating Room Nurses,** salary: \$230 plus \$10 'on call.' & \$10 postgraduate. **Charge Nurses,** salary: \$245. **General Duty Nurses,** salary \$230. Additional salary paid to nurses with 2 yrs. past experience, plus 4 annual increments to \$40. 28 days vacation, 10 statutory holidays. 1½ sick days cumulative. Room rent at nurses' residence \$20 per mo. Apply Director of Nursing, Trail-Tadanac Hospital, Trail, B.C.

**Royal Jubilee Hospital, Victoria, B.C.** invites applications for **General Duty Nurses** for permanent positions & vacation relief in 500-bed General Hospital. Salary \$227.50-\$262.50 5-day, 40-hr. wk. 4-wk vacation. 10 statutory holidays. Pension plan. Attractive employee benefits. Apply, Director of Nursing.

# WANTED

Nurses (Bilingual preferred,) Provincial Hospital Campbellton, Prov. of New Brunswick. General Duty Nurses with or without experience in Psychiatric Nursing. Salary commensurate with training & experience:

**MINIMUM — \$2,760 PER ANNUM**

**MAXIMUM — \$3,078 PER ANNUM**

**ANNUAL INCREMENT \$120**

Full civil service benefits after permanent appointment include 3-wk. annual vacation with pay, sick leave credits & superannuation. Comfortable living quarters & full maintenance supplied for \$42 per mo.

*Apply:*

**CIVIL SERVICE COMMISSION, P.O. BOX 1055, FREDERICTON, N.B.**

## NURSING INSTRUCTRESS (R.N.)

required immediately for

**Munroe Wing (psychiatric)**

**Regina General Hospital**

**Salary Range \$288 — \$350 per mo.**

Registered Nurse with professional experience & preferably postgraduate training in Psychiatric Nursing & Nursing Instruction, to be in charge of the training of affiliate student nurses in a 34-bed Psychiatric Ward.

Enquiries & requests for application forms should be sent to:

**The Public Service Commission,**

**Legislative Buildings**

**Regina, Saskatchewan**

## CITY OF WINNIPEG MUNICIPAL HOSPITALS

have openings for

### REGISTERED NURSES

40-hr. wk. Statutory holidays. Liberal sick time. Pension plan. Holiday allowance.

Accommodation available in  
nurses' residence.

**UNIFORMS LAUNDERED FREE**

**SALARY MIN.: \$215 — MAX.: \$248**

**EVENING DUTY ADDITIONAL \$10.**

*Apply to Superintendent of Nurses,*

**WINNIPEG MUNICIPAL HOSPITALS**

**MORLEY AVENUE, EAST**

**WINNIPEG 13, MANITOBA**



**General Duty Nurses for 35-bed hospital, 50 mi. from Toronto.** Salary: \$200 less \$30 for full maintenance. 8-hr. duty. Good personnel policies. Good living accommodation in home-like residence. Please furnish references to Supt., Stevenson Memorial Hospital, Alliston, Ont.

**General duty nurses for 65-bed hospital.** Gross salary: \$185-\$210. per mo. 44 hr. wk., statutory holidays. For further information apply, Director of Nursing Services, General and Marine Hospital, Collingwood, Ont.

**General Duty Nurses (All Departments) for New Wing opening in October.** Good personnel policies. For further information apply Director of Nursing, General Hospital, Belleville, Ontario.

**General Duty Nurses for 107-bed accredited hospital.** Starting salary: \$190 per mo. plus meals. Differential for evening & night duty. Periodic increases. Travelling expenses from point of entry into Ont. refunded after 6 mo. service. 44-hr. wk., 8 statutory holidays, 21 days vacation with pay, accumulated sick time. Medical & hospital plan subsidized. Room accommodation available in residence. Apply Supt. of Nurses, Kirkland & District Hosp., Kirkland Lake, Ont.

**General Duty Nurses for Medical, Surgical, Pediatrics, Obstetrics.** Good salary & personnel policies. Apply Director of Nursing, Victoria Hospital, London, Ont.

**General Duty Nurses for all departments.** Gross salary: \$210 per mo. if registered in Ontario \$200 per mo. until registration has been established. \$20 per mo. bonus for evening or night duty; annual increment of \$10 per mo. for 3 yrs. 44-hr. wk., 8 statutory holidays, 21 days vacation & 14 days leave for illness with pay after 1 yr. of employment. Apply: Director of Nursing, General Hospital, Oshawa, Ont.

**General Duty Nurses (3), O.R. Scrub Nurse for new 143-adult bed plus 30-bassinette hospital.** Good personnel policies. Starting salary: \$215 per mo. Apply Director of Nurses, Plummer Memorial Hosp., Sault Ste. Marie, Ontario.

**General Duty Nurses for 60-bed General Hospital.** Good salary & personnel policies. 44-hr wk. All statutory holidays. Sick leave allowance. Apply Supt., Public Hospital, Smiths Falls, Ontario.

**Graduate Nurses for duty on Obstetrical, Medical & Surgical Wards.** Personnel policies as recommended by the Assoc. of Nurses of the Prov. of Quebec. Please apply Director of Nursing, Queen Elizabeth Hospital of Montreal, 2100 Marlowe Ave., Montreal 28, Que.

**General Duty Nurses for 650-bed teaching hospital in central California.** Salary: \$288-\$337 per mo. 40-hr. wk. Liberal vacation, holiday & sick leave plan. Apply Personnel Office, 510 E. Market St., Stockton, California.

**General Staff Nurses for 400-bed Medical & Surgical Sanatorium, fully approved student affiliation & postgraduate program.** Full maintenance. Recreational facilities. Vacation with pay. Sick benefits after 1 yr. Blue Cross coverage. Attractive salary; 40-hr. wk. For further particulars apply Supt. of Nurses, Nova Scotia Sanatorium, Kentville, N.S.

**Staff Nurses for 600-bed General & Tuberculosis Hospitals with student programs.** In central valley, city of 108,000. State & Junior Colleges afford opportunity for advanced education. Salary \$300 with 4 annual increases to \$341. Full maintenance \$45 per mo. Liberal personnel policies. Apply Assoc. Director of Nursing Service, County General Hospital, Fresno, California.

**Staff Nurses for 500-bed General Hospital.** Beginning salary: \$300 per mo. with advancement to \$335 for those eligible for registration in the state of Michigan. Additional differential \$1.50 per afternoon or night. 40-hr. wk. Hospital & school of nursing fully approved. Apply Director of Nursing, The Grace Hospital, 4160 John R. St., Detroit 1, Michigan.

**General Staff Nurses (3) for 80-bed General Hospital with early promotion to supervisory positions possible.** Starting salary: \$332 per mo. 8-hr. day, 5-day wk. Pay for overtime work. Vacation: 2 wks. after 12 mos., after 5 yrs., 3 wks. Sick leave. Ultra modern nurses' home. Board & room \$40 per mo. Apply Director of Nursing, Sidney A. Sumby Memorial Hospital, 234 Visger Ave., River Rouge, Michigan.

**Staff Nurses for new hospital now being completed.** Salary: \$3700-\$4200 yearly; meals and laundry provided. Excellent personnel policies. Liberal vacation: statutory holidays; civil service benefits; sick time. Apply, Director of Nursing, Martland Medical Center, Newark 7, New Jersey or phone Mitchell 3-8800.

**General Staff Nurses (all departments) for 340-bed hospital conveniently located near New York City.** Beginning salary: \$260 per mo. \$30 bonus for 2:30-11 P.M. \$20 for 10:30 P.M.-7 A.M. Extra bonus for Operating & Delivery rooms. Increments every 6 mo. for 5 yrs. 40-hr. 5-day wk. 1 meal & laundering of uniforms gratis. Living quarters available at moderate cost. Excellent personnel policies. Overtime pay. 4 wk. vacation after 1 yr. 8 paid holidays. Sick time cumulative to 60 days. In-Staff educational program. Blue Cross ins. Pleasant working surroundings. Apply Director of Nursing Service, Presbyterian Hospital, Newark, New Jersey.



## **REGISTERED GENERAL DUTY NURSES**

*required at*

**WESTERN MEMORIAL HOSPITAL  
CORNER BROOK,  
NEWFOUNDLAND**

*for*

**MALE SURGICAL, OBSTETRICAL  
& PEDIATRIC FLOORS**

**Commencing salary: \$2,100 per yr. gross.**

**Return fare will be paid by hospital.**

*Apply:*

**SUPERINTENDENT OF NURSES**

## **REGISTERED NURSE FOR NIGHT SUPERVISOR**

*required at*

**WESTERN MEMORIAL  
HOSPITAL  
CORNER BROOK,  
NEWFOUNDLAND**

**Knowledge of Obstetrics  
essential.**

**45-hour week.**

**GROSS SALARY: \$2,600-\$2,800**

*Apply:*

**SUPERINTENDENT OF NURSES**

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**Assistant Director of Nursing, Head Nurse, General Duty Nurses for 150-bed Hospital.** 44-hr. wk. 31-days vacation plus statutory holidays, 2-wks. sick leave yearly. Write stating qualifications, salary expected, age & references to Director of Nursing, Grace Dart Hospital, 6085 Sherbrooke St. E., Montreal, Que.

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**General Duty Staff Nurses for 450-bed fully approved hospital.** Monthly salary range: Day Duty, \$330-\$349, P.M. & Night Duty \$340-\$359. 40-hr. wk., 2 consecutive rest days. Paid annual vacation. 7 paid holidays per yr. Accumulative sick time, based on length of service. Nurses' residence. Rooms at reasonable rates. Cafeteria. 4 uniforms laundered weekly without charge. Railroad passes issued based on length of service. Current registration in any state or Canada constitutes eligibility for Permit to work in California. Apply Chief Nurse, Southern Pacific Railroad Hospital, 1400 Fell St., San Francisco, California.

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**General Duty Nurse for 8-bed hospital.** Salary: \$235 gross, \$25 maintenance. \$5.00 increase every 6 mos. for 3 yrs. 1 mo. vacation with pay. Sick leave. Separate nurses' residence. Apply Mrs. I. Budrow, Matron, Kyle-White Bear Union Hospital, Kyle, Sask.

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**General Duty Nurses for 148-bed hospital.** Salary: \$270 per mo. with salary differential for rotating & specialties. 2 wk. vacation with pay after 1 yr. 10 days sick leave each yr. Apply Director of Nursing Service, Saint John's Hospital, Longview, Washington.

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**Graduate General Duty Nurses (2) for 16-bed hospital.** Salary: \$200 per mo. less maintenance of \$20 per mo. & income tax deduction. Increase of \$5.00 per mo. for each 6 mos. of service up to 2 yrs. 1 mo. annual leave with pay after 1 yr. service. Hospital is centrally located & close to lake resorts. Apply Miss E. L. Weaver, R.N., Matron, Municipal Hospital #43, Bentley, Alta.

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**Public Health Nurse (Qualified) for generalized program.** Salary: \$2,700-\$3,200 depending on experience. Annual increment \$100. 5-day wk. Pension plan. Blue Cross & P.S.I. available. Car provided or car allowance. Apply Dr. Charlotte M. Horner, Director, Northumberland-Durham Health Unit, Cobourg, Ont.

**Staff Nurses for 85-bed General Hospital.** Starting salary: \$285 per mo., \$10 differential. 38-hr. wk. Living accommodations available. Apply St. Ann's Hospital, Juneau, Alaska.

**Graduate nurses** for 56-bed hospital. Excellent working conditions. 8-hr. duty, rotating shifts. Apply Mrs. A. Kerby, Superintendent, Municipal Hospital, Stettler, Alta.

**Graduate Nurse (experienced),** capable of assuming position of Superintendent of Nurses in new, modern, 25-bed hospital. Required immediately. **Graduate nurses** (2) to complete staff. Salary scale according to R.N.A.B.C. policies. Board & room, \$35 per mo. Apply, Administrator, Lady Elizabeth Bruce Memorial Hospital, Invermere, B.C.

**Graduate Nurses for full-time positions in 91-bed General Hospital in Central B.C.** Expanding community with new hospital planned. Salary: \$235 per mo. depending on experience. 28 days annual vacation, liberal sick leave allowance & other perquisites. Transportation refund after 6-mo. service. Room & board available for nominal charge. Apply Director of Nursing, District Hospital, 1155 Lethbridge St., Prince George, B.C.

**Graduate Nurses (3)** for 24-bed hospital. Salary: \$230 per mo. if B.C. registered; less \$40 board, lodging, laundry. 1 mo. vacation after 1 yr. on full pay. 1½ days sick leave per mo. cumulative. Apply, stating experience to Matron, Terrace & District Hospital, Terrace, British Columbia.

**Graduate Nurses (General Staff Positions)** for General Hospital. Salary: \$239. per mo. as minimum & \$277.25 as maximum, plus shift differential for evening & night duty. 40-hr. wk. Temporary residence accommodation is available. Applicants not registered in B.C. should forward a letter of acceptance of registration in B.C. from the Registrar of Nurses, 2524 Cypress St., Vancouver, B.C. Please apply Personnel Dept., Vancouver General Hospital, Vancouver, B.C.

**Graduate Nurses & Dietician (1)** for new, very modern 88-bed hospital in a pleasant progressive town. Nurses salary: \$200 per mo. Annual increase \$10 per mo. for 3 yrs. 2-wk. shift rotation, bonus for night shifts. 1 hr. drive to Toronto & several resorts. Local swimming pool, bowling alleys, skating, theatres etc. Apply Director of Nurses, Dufferin Area Hospital, Orangeville, Ont.

**General Duty and Operating Room Nurses** for tuberculosis hospital. Personnel policies as recommended by A.N.P.Q. Apply, stating age, training and experience, to Director of Nursing, Grace Dart Hospital, 6085 Sherbrooke St. East, Montreal.

**Graduate Nurses** for general staff duty in a tuberculosis hospital for treatment of adult medical patients. For further information, apply to Director of Nursing, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, P.Q.

**Operating Room Nurses (2)** for 60-bed General Hospital. Good salary. 5½ day wk. Statutory Holidays. Apply Supt., Leamington District Memorial Hospital, Leamington, Ont.

**Operating Room nurse.** Postgraduate training not essential. A.N.P.Q. salary scale in effect. All graduate staff. 8-hr. day; 5½ day wk. Apply Director of Nursing, Montreal Children's Hospital, Montreal, Que.

**Laboratory technician** with knowledge of X-ray for 56-bed hospital. Pleasant working conditions Apply Mrs. A. Kerby, Superintendent, Municipal Hospital, Stettler, Alta.

**Dietitian (qualified)** for Teaching Hospital. Opportunity for advancement. Full maintenance. Fare from Canada for accepted candidate. For full particulars, write, giving qualifications & date available, Matron, King Edward VII Memorial Hospital, Bermuda.

**Certified Nursing Assistants for modern 42-bed hospital in northern Ontario.** Good recreation facilities. Excellent personnel policies. Apply Supt. of Nurses, New Liskeard & District Hospital, New Liskeard, Ontario.

**Supervisor (qualified.)** Good salary. Extra allowance for experience if French speaking. 5-day wk., 4-wk. vacation, 18 days sick leave cumulative annually. Car is provided. Half cost of uniform is allowed & half of Blue Cross. Workmen's Compensation. Good working conditions. Apply Sec.-Treas., Porcupine Health Unit, 164 Algonquin Blvd. E., Timmins, Ont.

**Public Health Nurse Grade 1.** British Columbia Civil Service, Dept. of Health & Welfare. Starting Salary \$255, \$260, \$266 per mo., depending on experience, rising to \$298. per mo. Promotional opportunities available. Qualifications: Candidate must be eligible for registration in British Columbia & have completed a University degree or Certificate course in Public Health Nursing. (Successful candidates may be required to serve in any part of the Province.) Cars are provided. 5-day wk. in most districts. Uniform allowance. Candidates must be British subjects; preference is given to ex-service women. Application forms obtainable from all Government Agencies, the Civil Service Commission, 544 Michigan St., Victoria, or 411 Dunsmuir St., Vancouver 3, to be completed & returned to the Chairman, Civil Service Commission, Victoria. Further information may be obtained from the Director, Public Health Nursing, Dept. of Health & Welfare, Parliament Bldgs., Victoria, B.C.

**Public Health Nurses for Kent County Board of Health Unit.** Minimum salary: \$2,840 with annual increases of \$150 per yr. for 4 successive years. 38-hr. wk. 3 wks. vacation with pay. All statutory holidays. 2 days a mo. sick leave accumulative to 48 days. Uniforms provided. Ideally located, bordered on the south by Lake Erie & by Lake St. Clair on the west. The city of Chatham being located in the centre of the county with the cities of London, Sarnia & Windsor, Ont. & the city of Detroit, Mich. all within 1 hr. drive making Kent County a most desirable place in which to live & make a living. Apply W. M. Abraham, Sec.-Treas., Kent County Board of Health, 7th St., Chatham, Ont.



# GRADUATE NURSES

Considering locating in Metropolitan Toronto

Enquire now concerning September & October appointments in enlarged new 125-bed suburban Toronto hospital. Advantages offered include: —

- Congenial working conditions of a smaller city hospital.
- Convenient public transportation to downtown Toronto.
- Attractive residence accommodation, if desired.
- Appointment to service of your choice.
- Good personnel policies with above average salary schedule.

Supervisors — \$260 increasing to \$310

Head Nurses — \$245 increasing to \$295

General Duty — \$225 increasing to \$275

Extra allowances for postgraduate training.

Apply Director of Nursing:

**HUMBER MEMORIAL HOSPITAL, 200 CHURCH ST., WESTON  
TORONTO 15, ONTARIO**

## CITY OF HAMILTON

has opening for Public Health Nurse

Must be a Graduate Nurse and should have a Public Health Nursing Certificate. 5-day, 36 1/4-hour week, all fringe benefits. Starting salary commensurate with previous experience.

*Apply to:*

**DIRECTOR OF PERSONNEL  
CITY HALL  
HAMILTON, ONTARIO**

## PROVINCE OF NOVA SCOTIA DEPARTMENT OF PUBLIC HEALTH, REQUIRES NURSES

Applications are invited from Graduate Nurses with or without public health training for positions in the Division of Public Health Nursing, Department of Public Health, Nova Scotia. Bursaries available for training. Salary dependent on training and experience.

*For further information and application forms  
apply to*

**DIRECTOR OF  
DIVISION OF PUBLIC HEALTH NURSING  
DEPARTMENT OF PUBLIC HEALTH  
PROVINCIAL BUILDING  
HOLLIS STREET, HALIFAX, N.S.**

*or*

**NOVA SCOTIA CIVIL SERVICE COMMISSION  
P.O. BOX 943, HALIFAX, N.S.**



# REGISTERED NURSES

FOR GENERAL DUTY AND OPERATING ROOM

*opportunities available at*

## THE MONTREAL GENERAL HOSPITAL

*For further particulars write to:*

**DIRECTOR OF NURSING, 1650 CEDAR AVENUE, MONTREAL 25, P.Q.**

**Public Health Nurse (Qualified)** for expanding program in growing suburban municipality. Min. salary \$3,200 with regular annual increments to \$3,680. Further increases by merit rating. Starting salary based on experience. Car allowance \$670 per yr. 4 wks. vac. after 1 yr. Blue Cross and pension plan. For further details apply, Personnel Director, Township of Etobicoke, 4941 A Dundas Street W., Toronto 18. Tel. BE 1-4161.

**Public Health Nurse (1) for generalized program** in rural & semi-urban area adjacent to metropolitan Toronto. Excellent working conditions including pension plan, group ins. & transportation arrangements. Apply Dr. R. M. King, York County Health Unit, Newmarket, Ont.

**Public Health Nurses (Qualified)** for City of Oshawa. 4 vacancies. Generalized program in urban area. Starting salary without experience: \$3,100. Annual increment \$120. Transportation provided. 5-day wk. Pension & hospitalization plans available. Apply A. F. Mackay M.D., Medical Officer of Health, City Hall, Oshawa, Ont.

**Public Health Staff Nurses (2) for generalized program** in city of 43,000. Blue Cross & P.S.I. employer shared. Transferrable accumulative sick leave & pension plans. Workmen's Compensation. Group ins. available. Transportation provided or allowance — 10¢ first 2,000 mi., 8¢ per mi. thereafter. 5-day wk. 1 mo. vacation with extra time at Christmas. Salary scale: \$3,000 for inexperienced nurses to start with annual increments of \$150. All starting salaries dependent on experience. For further information please write supplying details of training & experience to Medical Officer of Health, City Hall, Peterborough, Ont.

**Public Health Nurses (qualified.)** Salary: \$3,100 depending on dist. served, less if in the Timmins area. Annual increment \$150 per annum for 4 yrs. Additional allowance for experience & if French-speaking. 5-day wk. 4-wk. vacation, 18 days sick leave annually (cumulative.) Car is provided. Half cost of uniform is allowed & half of Blue Cross. Workmen's Compensation. Good working conditions. Apply Sec.-Treas., Porcupine Health Unit, 164 Algonquin Blvd. E., Timmins, Ont.

**Registered Nurses for staff nursing** in new & beautifully equipped 100-bed hospital in the Pacific northwest. Only 6 mi. from the Pacific Ocean. Delightful climate. Beginning salary: \$290 for 40-hr. wk., \$10 additional for p.m. & night duty. Apply Director of Nurses, County General Hospital, Tillamook, Oregon.

**Registered General Duty Nurse for 30-bed hospital.** Salary: \$225 plus \$10 night duty. Apply Administrator, Our Lady of the Rosary Hospital, Castor, Alberta.

**Graduate Nurse for general duty on surgical floor.** Liberal personnel policies. Residence facilities available. Apply Director of Nursing, Sudbury & Algoma Sanatorium, Box 40, Sudbury, Ontario.

**General Duty Nurses (2) for 20-bed modern hospital.** Salary: \$200 per mo. plus full maintenance. Usual holidays with pay, sick leave etc. Fare refunded one way after 1 yr. Separate modern nurses' home. Apply Matron, Union Hospital, Vanguard, Sask.

**Registered Nurse (Immediately) with experience in nursery:** Salary: \$235 gross. Room & board \$30. 40-hr. wk. For further information apply Director of Nurses, Misericordia Hospital, Haileybury, Ont.

**Registered Nurses (Under age 50) General Duty: \$300-\$350 (5 steps.) Head Nursing: \$315-\$375 (5 steps.)** Retirement plan, sick leave benefits. 3-wks. vacation, holidays. Modern nurses' residences. State eligibility for California registration. Rehabilitation ward recently opened. Tuberculosis, other chest diseases chronic illness. Interesting & challenging positions for qualified registered nurses. Submit photo to Director of Nursing Services, Tulare-Kings Counties Hospital, Springville, California.

## **GRENFELL LABRADOR MEDICAL MISSION**

The Grenfell Mission requires a Laboratory Technician, Occupational Therapist and Nurses for their headquarters at St. Anthony, Newfoundland. These are positions which combine work in a modern hospital with the opportunity for service to the people of the Canadian Northland.

For full information please write:

**MISS DOROTHY A. PLANT, SECRETARY**

**GRENFELL LABRADOR MEDICAL MISSION, 48 SPARKS ST, OTTAWA 4, ONTARIO**

## **PEDIATRIC INSTRUCTOR**

Responsible for classroom and clinical instruction in pediatric nursing & co-ordinating maternal & child care program in school where organizational set-up permits stressing of patient-centred care and student-centred learning activities.

*For further information apply:*

**DIRECTOR, SCHOOL OF NURSING, METROPOLITAN GENERAL HOSPITAL, WINDSOR, ONTARIO.**

## **DIETITIAN**

**FOR**

**VICTORIA HOSPITAL, RENFREW, ONTARIO**

**APPROXIMATELY 100-BEDS**

**SCHOOL OF NURSING WITH 30-40 STUDENTS**

State qualifications, experience and salary expected.

*Apply, with references to*

**CHAIRMAN, PERSONNEL COMMITTEE, VICTORIA HOSPITAL, RENFREW, ONTARIO**

## **UNIVERSITY HOSPITAL**

**SASKATOON, SASKATCHEWAN**

*Requires*

General Staff Nurses for Medical, Surgical, Obstetrical and Pediatric Services. Forty hour week. Salary \$220 to \$260 gross per month. Differential for evening and night duty, Residence Accommodation if desired.

*Apply to:*

**DIRECTOR OF NURSING, UNIVERSITY HOSPITAL,  
SASKATOON, SASKATCHEWAN**

## **OPERATING ROOM SUPERVISOR ASSISTANT OPERATING ROOM SUPERVISOR**

Experienced, postgraduate preferred. This is a modern, well-equipped department. Salary commensurate with qualifications and experience.

*Apply:*

PERSONNEL DIRECTOR, SARNIA GENERAL HOSPITAL, SARNIA, ONTARIO

## **DIRECTOR OF NURSING**

*for*

**VICTORIA HOSPITAL, RENFREW, ONTARIO**

Approximately 100-beds

School of Nursing with 30-40 students.

Qualifications desired: Degree or postgraduate certification in nursing service and school of nursing administration and some experience.

Perquisites: Private 3-room apartment in residence; full maintenance and laundry provided.

Initial salary: \$250-\$300 per month depending on qualifications and experience.

*Apply, with references to*

CHAIRMAN, PERSONNEL COMMITTEE, VICTORIA HOSPITAL, RENFREW, ONTARIO

## **REQUIRED IMMEDIATELY**

**Head Nurse, Nursery**

**(Postgraduate experience preferred)**

**General Staff Nurses, All departments**

**(\$225 per mo. plus laundry)**

New 300-bed General Hospital. Excellent Personnel Policies.

*For further information apply:*

Director of Nursing, Memorial Hospital, Regent St. S., Sudbury, Ontario.

## **REGISTERED NURSES**

**\$2,610-\$3,360**

## **CERTIFIED NURSING ASSISTANTS**

**\$2,040-\$2,220**

**WESTMINSTER HOSPITAL  
TORONTO**

Five-day Week

**SUNNYBROOK HOSPITAL  
LONDON**

Application forms, available at your nearest Civil Service Commission Office, National Employment Service & Post Offices, should be forwarded to the

**CIVIL SERVICE COMMISSION,  
25 ST. CLAIR AVE. E., TORONTO 7, ONTARIO**



## **VICTORIAN ORDER OF NURSES FOR CANADA**

*has Staff and Supervisory positions in various parts of Canada.*

### ***Personnel Practices Provide:***

- Opportunity for promotion.
  - Transportation while on duty.
  - Vacation with pay.
  - Retirement annuity benefits.

*For further information write to:*

**Director in Chief,**  
Victorian Order of Nurses for Canada,  
193 Sparks Street, Ottawa 4, Ont.

## **DIRECTOR OF NURSING**

Fully accredited suburban hospital recently enlarged to 125 beds requires Director to take charge of Nursing Service of 110 personnel — No training school.

- Postgraduate training in Nursing Administration &/or equivalent experience required.
- Salary fully commensurate with the importance of the position.
- Full scope for progressive direction & personal satisfaction.
- Congenial working conditions in a well established smaller city hospital.

Enquire in confidence to

**Administrator: HUMBER MEMORIAL HOSPITAL, 200 CHURCH ST., WESTON, TORONTO 15, ONT.**

## **REGISTERED NURSES**

### **Required Immediately**

For vacancies in medical & surgical departments, also operating room. Minimum salary: \$2,834 per yr. Rotating shifts. Health benefits available. Excellent personnel policies.

*Apply:*

**PERSONNEL DEPARTMENT, SARNIA GENERAL HOSPITAL, SARNIA, ONTARIO**

## **GENERAL STAFF and PSYCHIATRIC NURSES**

### ***Required to staff***

New wing of 350-bed General Hospital.

Basic salary: \$250 per mo. with yearly increments of \$120 for 3 years.

Differential for evening & night duty.

*For further information apply to:*

**DIRECTOR OF NURSING SERVICES, METROPOLITAN GENERAL HOSPITAL  
1995 LENS AVENUE, WINDSOR, ONTARIO**

# Official Directory

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### 270 Laurier Ave., W., Ottawa

<b>President</b> .....	Miss Trenna G. Hunter, Metropolitan Health Com., City Hall, Vancouver, B.C.
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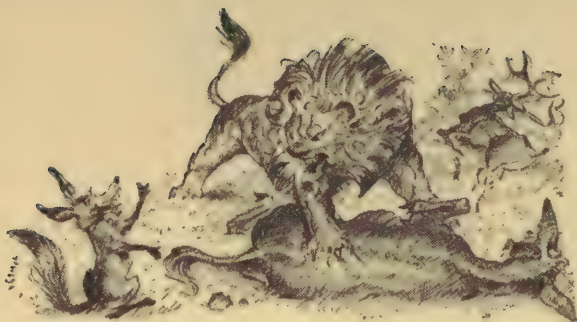
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## A Lion, Ass and Fox

A Lion, an Ass and a Fox  
ran down a Stag and the  
Ass was to divide the Prey.  
As he was doing this  
Honestly and Innocently,  
into three equal Parts, the

Lion fell on and kill'd him.  
Then the Lion bad the Fox  
divide: who had the wit to  
put the Whole to the Lion's  
Share, Saving only a Miser-  
able Pittance for him self.

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# THE CANADIAN NURSE

## *L'Infirmière Canadienne*

VOLUME 52

NUMBER 11

NOVEMBER 1956

**862** NEW PRODUCTS

**869** IMPROVING NURSING SERVICE.....*M. G. Arnstein*

**875** CREATIVE NURSING.....*M. E. Schwier*

**880** THE BIFOCAL APPROACH.....*A. Sinclair*

**884** K.P. FOR DOUBLE-DUTY HOMEMAKERS.....*L. P. Bell*

**885** HYDROCEPHALUS.....*J. Jenkinson*

**891** SCARLATINE PLUS ENDOMYOCARDITE.....*H. Payer*

**893** SÉLECTION

**896** NURSING ACROSS THE NATION

**898** ANNUAL MEETING IN SASKATCHEWAN.....*L. Wilson*

**900** LE NURSING À TRAVERS LE PAYS

**904** THE MEANING OF REHABILITATION.....*F. G. Wellard*

**910** IN MEMORIAM

**912** BOOK REVIEWS

**920** NEWS NOTES

**922** EMPLOYMENT OPPORTUNITIES

*Editor and Business Manager*

MARGARET E. KERR, M.A., R.N.

*Assistant Editor*

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# Between Ourselves

WITH THIS ISSUE, the publication of addresses given at the 1956 Biennial Convention in Winnipeg is completed. It has been a very worthwhile series. It is our hope that every nurse will avail herself of the opportunity to study these outstanding papers.

\* \* \*

Reports reaching us of student enrolments in the new classes entering our schools of nursing this fall seem to indicate that the activities of the Student Recruitment Committees are paying dividends. Numbers of schools have reported capacity classes.

Beginning this year, a large proportion of the directors of nursing have been availing themselves of the offer, made by the Editorial Board of *The Canadian Nurse*, to present a complimentary subscription to the student who receives the highest standing in theory and practice during her preclinical period. When a school takes only one class in each year the award subscription runs for two years. When there are two classes, the subscription period is divided between the two winners, each receiving the Journal for one year.

It occurs to us that here is a very tangible way in which graduate subscribers could extend a helping hand to the youngsters. If you remember back to your own student days many of you will doubtless recall that there wasn't too much money in your personal bank account. The \$5.00 that would pay for a three-year subscription to *The Canadian Nurse* was needed for a dozen other purchases. Besides, why subscribe? "There's a copy in the library!"

Most of today's student nurses are just

as hard pressed to make ends meet for personal expenditures as we were. Many of them who would like to receive their own copies of the Journal put it off until later for financial reasons. So here is our thought — how about "adopting" a preliminary student of your own school of nursing or in the hospital where you are working and giving her a subscription to the Journal as a Christmas present?

If you know the name and address of the student you would like to assist in this way, send your order to us. We will send a gift card at Christmastime telling her about it. If you would like to make such a Christmas donation but do not know the name of a preliminary student, send us your cheque. We will write to the school of nursing of your choice and ask the director of nursing to select a deserving recipient. Let us hear from you.

\* \* \*

While we are on the subject of gift subscriptions, you may be interested to know that several nurses have asked us to transfer their subscriptions to nurses in some foreign country who are unable to send money out. We wrote to Miss Helen McArthur for suggestions regarding Korean nurses. She gladly supplied some names.

Most of the subscriptions to foreign nurses that were started through the gifts you made to the War Memorial of the Canadian Nurses' Association are now terminating. Regretfully, many of these nurses have written us that though they shall miss the regular copies, they cannot pay for renewals. Here is another place you might put that \$5.00 that is burning a hole in your wallet!

Do you know the difference between the lengths of Canadian and American sheets? To help avoid confusion in the buying of sheets, remember that "Torn Length" is the American basis of marking: "Hemmed Length" is the Canadian basis. If you buy a sheet with U.S. marking, you should subtract about five inches (5") from the listed length to have a sheet comparable with the Canadian length, measured *after* hemming.

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N.C. in *Saturday Review*



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Edited by DEAN F. N. HUGHES

PUBLISHED THROUGH COURTESY OF *Canadian Pharmaceutical Journal*

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**Administration**—Usual adult dose: 1 pulvule (250 mg.) 4 times daily.

**Warning**—Potent drug. May cause unfavorable reactions in some individuals. To be used only under the close supervision of a physician.

---

## STREPTOHYDRAZID

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**Indications**—A powerful tuberculostatic agent. Active in vitro against streptomycin-sensitive and streptomycin-resistant strains of *M. tuberculosis*, as well as against isoniazid-sensitive and isoniazid-resistant strains.

**Administration**—In general, the contents of a single dose vial (1.4 gram streptohydrazid sulfate) should be administered daily by the intramuscular route only.

---

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**Description**—Each 15 cc. tablespoonful contains: sulfacet (phthalysulfacetamide) 1.0 Gm., kaolin 1 mg., pectin 150 mg., thiamine HCl 1.0 mg., spasex (homatropine methylbromide) 0.32 mg.

**Indications**—Infections and non-specific diarrheas, summer diarrheas, infantile diarrheas, bacillary dysentery and salmonellosis, ulcerative colitis, enteritis and irregular motility.

**Administration**—One tablespoonful every 4 hours or as prescribed. Children, according to weight.

---

## STYRION

**Manufacturer**—Glaxo (Canada) Ltd., Toronto.

**Description**—Each tablet contains: 0.4 gm. polyaminostyrene, an acid-binding resin.

**Indication and Administration**—In simple hyperacidity as in acid dyspepsia and some forms of gastritis, 2 tablets are usually adequate, repeated as necessary, but usually once after a meal suffices. In more severe cases, e.g. gastric ulcer, large doses of up to 8 tablets may be required at first, later 2 tablets after meals may be sufficient. Tablets may be chewed or swallowed with water.

---

## TES-TAPE

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**Manufacturer**—Charles E. Frosst & Co., Montreal.

**Description**—Each tablet contains: Sulfamethazine 167 mg., sulfadiazine 167 mg., sulfamerazine 167 mg., crystalline potassium penicillin-G 200,000 I.U.

**Indications**—For treatment of infections caused by organisms sensitive to the action of penicillin and/or the sulfonamides.

**Administration**—One to 4 tablets followed by 1 to 2 tablets every 4 to 6 hours.

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*The Journal presents pharmaceuticals for information. Nurses understand that only a physician may prescribe.*



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# THE CANADIAN NURSE

## *L'Infirmière Canadienne*

A MONTHLY JOURNAL FOR THE NURSES OF CANADA  
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VOLUME 52

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**MONTREAL, NOVEMBER, 1956**

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## Improving Nursing Service

MARGARET G. ARNSTEIN, M.A., M.P.H.

I CHOSE THE SUBJECT of my talk to remind myself that there is something in life besides studies, that things can be accomplished without necessarily doing a study first. There is a danger of forgetting this when one is immersed in studies and observes, time after time, how they contribute to action programs. There are those who think that we are study mad in the United States. I suspect that you may have a more balanced approach to the values of research. Still, it may be of interest to you to examine with me some of the things currently being done to improve nursing service and the place of the study in the total pattern.

We are constantly changing various aspects of our nursing services and, we hope, improving them. Alterations are necessitated by changes in medical science and practice, by changes in the society we serve, and changes in ourselves who are part of this society. Medical science has made such startl-

ing advances in the last 15 to 20 years that the whole picture of sickness and health has undergone a profound alteration. You are familiar with these things — the diminishing importance of the acute communicable diseases, at least as a cause of death; the effect of the antibiotics on the recovery of people suffering from all types of infections, the advances in surgery.

Radical changes in nursing practice have been required as a result of these developments, which also have been the cause of some of the most significant social changes. Greater success in hospital treatment has increased the use of our hospitals and, consequently, the demand for more hospital beds. Reduction of mortality in the younger age groups has increased the number of older people and it also has increased the numbers needing rehabilitation. Many who once died now live with some impairment and the extent to which this interferes with normal living depends partly on the success of rehabilitation.

Other social changes have also influenced nursing — the shorter work week, the higher proportion of young

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people finishing high school and going to college, the acceptance of the philosophy of insurance against disasters of all kinds including sickness, and the trend toward increased specialization.

It may be partly this pressure to change, the rapidity with which we have *had* to change, that has made us so aware of the need to improve. We have had no chance to settle into a comfortable "usual" way of doing things.

Many of the important changes and improvements have come about not because of formal studies but because some person, or a group of people, thought it would be better to do something a new way. This thought comes from somewhere — from a series of observations made more or less subconsciously during the day's routine; observations of gaps in service; of needs for better nurse-patient relationships or more adequate teaching. These things are not formally recorded or added up on paper, but accumulate in one's mind so convincingly that they constitute a basis for action.

Take, for example, *team nursing*. My examples will have to come from our experience in the States. If they do not fit your experience, I hope you can supply examples of your own. The important features of team nursing are:

It provides a medium through which *all* nursing personnel may readily exchange information about the patients under their care. Team nursing relieves the head nurse of the burden of individual assignments and the individual supervision of each member of the nursing staff, a sometimes wasteful application of her skills.

Each group of patients has an opportunity to know the members of the team assigned to that group, and is not forced into adjusting constantly to different personalities with different techniques and skills.

The person or persons who first proposed team nursing observed that ancillary personnel usually had no chance to listen to the morning or evening reports of the condition of patients in their unit. Neither was there any other planned way to inform them about the patient's progress during the previous eight hours. Yet these auxiliary personnel were expected to

give nursing care — and they *were* giving it — completely in the dark, with no real knowledge of the patients' needs.

It could also be seen that many people were coming to the head nurse bringing requests and asking, "What do I do next?" The head nurse did not have time to give any of them her full attention. She was also assigning many duties without any over-all plan, meeting each need as it arose. Thus, each patient might be cared for by every member of the nursing staff in one day.

These imperfections in relationship between nursing service personnel were noted on separate occasions and not spelled out in sequence as I have done here. However, the facts and their implications were put together. A way of overcoming the difficulties was worked out and this method has been labeled "team nursing."

In the same manner, nurses have improved nursing service in the hospital and the home in hundreds of ways. They found ways for small, slender young women to turn large men in bed with ease and comfort to the patient; they found ways to support a patient on his side so he felt secure; they improvised backrests in the home from kitchen chairs, they devised ways to keep covers off the patient's injured part; they have constantly improved their methods of preventing bed sores. I could go on and on, but there is no need to for you can supply from your experience other examples of improvement in nursing service which have been achieved without a planned study but not without studying the situation.

Having decided that a certain course of action is desirable, how does one bring it about? *By group participation in group decision*. There are studies that give strong support to this method of bringing about change in the behavior of groups. I came across one method recently that had been made in a pajama factory.

Management methods had to be changed frequently. The changes were routinely explained to the employees by a man from the "front office." Invariably, a large number of workers quit rather than alter their work habits. Those who stayed on the job never made

their work quotas and had more difficulty learning the new methods than did new employees. As a remedy, the company decided to let the employees share in the process of making decisions. This participation was made available in different ways. One group was permitted to appoint a committee to decide how, when, and where a job would be altered. A second group studied the job together and, on the basis of what management had conveyed to them of emerging needs, they made group decisions on new methods of work. A third group remained on the old system of "briefings only" from the management office.

When the results were analyzed, it was found that Group One — those who appointed a committee — were no less productive than formerly and had learned the new work method with relative ease; the percentage of workers who quit was low. Group Two — those who were permitted optimum participation in planning for the change — learned the new methods in amazingly little time, their turnover rate was negligible, and their rate of production was considerably higher than formerly. I need not add that Group Three showed evidence of the same destructive negativism — high turnover, slow learning capacity, and inadequate productivity.

Before going on to discuss the use of studies as a means of effecting improvement in services, I should like to recapitulate. Change can be brought about by common sense and insight, or by applying the knowledge obtained through experience. During either of these efforts to cause constructive change, we are actually going through most of the steps of a formal study without being aware of it. We are identifying needs, or gaps in program. We are collecting data — commonly called learning through experience. We are making decisions, using our faculty of judgment. We are solving problems.

In order to solve a problem we must first recognize that it exists. When we are not engaged in a formal study, we may by-pass the difficult job of defining the problem in exact terms and go on to making observations of our own — or learn by reading the results of someone else's observations. More often than not, these are "impressions" rather than conscious or

planned observations, but because they are the outgrowth of experience they serve as a basis for deciding what needs to be done. The group shares in deciding on a course of action and then helps in formulating the action program.

If we can make improvements in nursing service in this manner, why do we bother with time-consuming, and often costly, formalized studies? When and why do we decide to conduct a study to see how we can improve services? We may undertake a study because the previous efforts to improve service have not given us the results we hoped for. We may need more penetrating information than can be obtained from casual consideration of the facts, or even from careful personal analysis of any given situation. Some other reasons are:

1. A study will give us new information — facts not known to anyone before, facts that have general application.
2. It can give us facts about a particular situation.
3. It can give us facts that may be fairly obvious to some people but are not recognized or accepted by the group doing the study. Thus it serves to give people a new look at a familiar situation.
4. A study can also serve as a motivating force to change. This is more likely to happen if the people who have to make the change participate in making the study.

I am limiting this discussion to social studies, the type most frequently used as a basis for improving nursing service. I shall not discuss laboratory or even strictly clinical studies, though certainly my first two points apply to all studies.

I was asked to describe some of the studies we have been doing in the Division of Nursing Resources. You may be interested in the study method we have developed for studying the time distribution of the activities of all nursing personnel on a patient unit. This study is very similar to your head nurse study. The general problem was the same as the one stated in your study, "shortage of nurses," and reflected the need for those who were available to use their time as efficiently as possible.

Only certain aspects of total job effectiveness are included in this study



method. One aspect to be studied is the amount of time each nurse is spending with patients — or in their presence. This latter item was included because we were constantly hearing from patients how seldom they saw a nurse. This seemed like a legitimate complaint which should be explored further, inasmuch as we were all in agreement that the very essence of nursing care is the nurse-patient relationship. Another important aspect of job effectiveness covered in this study is the extent to which each worker is performing the tasks which are proper to her job.

This study, described in our manual entitled, "How To Study Nursing Activities in a Patient Unit," was designed to point up facts not readily recognized or accepted and to motivate people to change. So that hospitals could make the study themselves, the manual describes the method, step by step, from the first desire to make the study to the final step of preparing the report. The manual includes also a brief suggestion on how to initiate action following the study.

Because we thought that involvement of the nursing staff was essential if action were to result, the manual suggests not only that the purpose of the study be discussed with the entire staff but that the observers be members of the hospital staff. The training the observers receive — first, in understanding the definitions and the reasons for the classifications used, and secondly, in the actual process of observing and recording and classifying activities — has proven so valuable that often nurses who are not to be observers in the study have also participated in the training program. We recommend about 14 hours of training which includes group discussion and a two-hour practice period on the wards.

You may be interested to hear some of the results of nursing activity studies that hospitals in the United States have made to date. I have selected just a few examples of the kinds of action which have occurred.

Many of the hospitals reported that when they were able to relieve their head nurses of non-nursing duties, job satisfaction increased noticeably among the entire staff. One hospital found that

by better utilization of nursing personnel they could open two new floors without employing additional nurses. Complaints about work pressures were universally reduced. Head nurses found they were able to spend more time in supervisory activities and staff nurses received guidance when they needed it. The effects of the studies were apparent even in the schools of nursing. In several instances, the faculties of nursing schools were able to use the study findings to teach students how to organize their work assignments; this produced greater satisfaction for them as they were consequently able to spend more time on activities with patients.

The majority of hospitals agree with us that it is important to re-study in order to measure accurately the amount of change occurring following the initial study. Frequently, a "feeling of improvement" prevails just from doing a study. While this is healthy, it is even better to know exactly what has resulted from a study.

Studies of the distribution of nursing time merely set the stage for improvement of the quality of nursing care of the patient. These time studies tell us how much time the nurse is spending with the patient and may even tell us what she is doing. They do not tell us how she is doing it. In most cases the nurse's presence will reassure the patient, her ministrations will benefit him, but often not to the extent she might if she had more understanding of the patient's needs. Occasionally she may even do harm to the patient.

A patient in a medical unit had a very unstable blood pressure. Sharp rises were always accompanied by severe headaches and nausea. The occurrence of these increases in blood pressure baffled the doctors because they were not correlated with change of medication or activity. The head nurse on the unit observed that a certain staff nurse was always in attendance when these episodes occurred. Inquiry revealed that this nurse upset the patient. "In fact" the patient said, "I don't think she believes I am suffering as much as I am." The nurse was reassigned as an experiment. It worked. The capricious blood pressure rises stopped immediately.

Although this situation is rare, in a much less harmful manner it may occur and not even be recognized



whenever nurses acquire extra time to spend with patients and do not know how to spend it profitably. Most hospitals that have done time studies now recognize the value of providing in-service instruction to help the nursing staff learn how to spend their time with patients to best advantage.

We have some knowledge of the patient's needs and which of these can be supplied by nursing service. We need much more information and understanding of this whole area. So far, we have very little knowledge on how to help the nurse meet these needs of patients. Marion Cleveland, director of nursing at Presbyterian Hospital, New York, said a few years ago that sometimes it seemed as though we were nursing the equipment attached to the patient instead of the patient.

If we were given the opportunity of choice, could we ever choose to nurse the patient's anxieties instead of following techniques, if both could not be done? Many times we could not, for if we delayed keeping the various suction operating properly we might kill him at once. But perhaps there are times when we could. Dr. Hargreaves, director of Mental Health in WHO, once said he would rather have mothers take care of their children in hospital and risk a few infections from faulty technique than risk what he thought were much greater chances of impairing the child's emotional health if he were separated from his mother.

We need much more information in the whole area of the effect of emotion on health and the role the nurse can play in this scene, in view of the many demands not only on her time but also on her intellectual and emotional capacities.

We nurses are in an excellent position to make the observations that will lead to conclusions in studies of this type for, whether we are with the patient 30 per cent or 50 per cent of our day, we are with him more than any other group. We need not start with a big world-shaking study. We can do something as simple as developing an experiment with different kinds of early ambulation, for example. We could try out short and frequent periods out of bed in contrast with longer and fewer ambulatory incidents. Then

we could test the effects of both on the patient's pulse and blood pressure, observe any evidence of fatigue, and note his verbal responses about being up. The conclusions from the recorded observations should give us some interesting clues to the relationship of nursing to patient welfare, both emotional and physical.

I have purposely mentioned a very simple study to demonstrate to you the fact that valuable data may be collected within the framework of everyday nursing experience.

When we say we need more nurses, do we know what we need them for? Some hospitals are so short that they need more nurses in order to have one nurse on duty in each area for the full 24 hours. Others know that medications are given late, treatments delayed because of lack of staff, etc. But other hospitals which meet these basic requirements also say they need more nurses. When asked for specific examples of things that are not being done, many hospitals can answer only in generalities. Hospitals with relatively large numbers of nurses per patient were crying "shortage" as loudly as their neighbors with much lower nurse-patient ratios.

For these reasons, we are now in the process of conducting a study in 60 hospitals to find out whether there is any correlation between hours of nursing care and number of deficiencies in nursing service. This has a very negative sound, but we want to find out what is *not* getting done that might be done if there were more nurses. We have tried to get a record of events as patients, nurses and doctors perceive them. While this method is more subjective than if we used observers, it was the only practical one we could develop that could be done by hospitals themselves. It also fitted the objectives of the study, for the pressure for more nursing service comes not only from patients, but also from the perception of care by the nursing service and medical personnel.

The questionnaire is simple and has been filled out without difficulty by 20,000 people. The development of the questionnaire, however, was not simple. It took us over a year! Research is like the iceberg — two-thirds invisible.

Research is also international and

in our study designed to diagnose the ills of an outpatient department we drew heavily on the experience of Mr. H. A. Goddard and his associates in England.

Research is never finished. Our understanding of the why of living matters is very meager still. Research in a basic science presents new problems to a related applied science and generates the need for more research. Man's curiosity — and certainly woman's — is never satisfied. Research has been defined as seeking the answer to a question pressing for solution. Research in nursing is only beginning.

We can look forward to a long line of nurses stretching far into the future, seeking answers to the questions we have and to many we have not dreamed of yet. Let us hope that thoughtful, inquiring minds will be given encouragement and the full support, not only of the nursing professions, but also the other professions with whom they work.

Research is not new in nursing. Florence Nightingale made careful studies of nursing a hundred years ago when she started the profession. May her research lamp, as well as her lamp of comfort, continue to inspire us.

## In the Good Old Days

(*The Canadian Nurse* — NOVEMBER, 1916)

A study of 403 applicants for practical nurse work showed that the rejected probationer is by all odds the most difficult type to deal with. She has been long enough in a hospital to acquire certain habits so overestimates her worth, objects to housework, wants to wear white dresses on duty, be called a "trained nurse" and is generally insubordinate. Most of these workers wanted from \$20 to \$25 a week for their services instead of the \$2.00 a day they are permitted to charge.

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A fundamental need of nurses is education, liberal education. We readily believe it as a theory but stumble at its practice for we know there is and always will be more nursing needed than can be done by only the highly efficient. The need is for a more pronounced *grading of nurses*. School teachers with second class certificates secure their first class standing, with its increased salary, only by proving their natural talent, applying themselves and spending their money to improve themselves. Why not require a similar talent, application and expense test for nurses?

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Until recent years, it was considered that the country with the highest infant mortality was the most fortunate. How frequently one still hears the assertion that delicate infants should not live; that efforts directed along this line are futile; that hospitals for the saving of sick children are but misguided philanthropy . . . Child welfare nurses spend

much of their time combatting these misconceptions. Most of those sickly infants were healthy at birth and are victims of bad environment, poor feeding and neglect.

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"How are we going to prevent our country from being swamped with foreign nurses when this war is over?" writes one nurse serving overseas with the C.A.M.C.

## Poliomyelitis

The outlook in poliomyelitis, both immediate and long range, appears favorable, according to the statisticians of the Metropolitan Life Insurance Company. Through the first eight months of 1956, reported cases of the disease in the United States were 45 per cent fewer than in the comparable period of last year.

An outstanding feature of the long-term poliomyelitis trend, say the statisticians, is a pronounced shift to the older ages. The disease now claims more of its victims among older children and among adults up to age 35 than it formerly did.

The shift in the age pattern may result primarily from a rise in the age at which natural immunity is acquired, possibly reflecting lessened frequency of exposure among children. A sharp drop in, 1955 in the frequency of hospital admissions of cases with paralytic poliomyelitis at ages 7 and 8, it is noted, coincided with the wide use of Salk vaccine at those ages.



# Creative Nursing

MILDRED E. SCHWIER, M.A.

THE NATIONAL LEAGUE FOR NURSING has as its major purpose the betterment of nursing for people through the promotion of improvement in nursing service and nursing education. I have been invited to report to you on some of the progress being made by schools of nursing in their efforts to assist nursing students to become prepared to give better care, especially progress which relates to the objectives of schools.

Identifying and stating objectives for a school and using them as a basis for curriculum developments are not new activities. Florence Nightingale stated objectives for nursing and for nursing education. In her *Notes on Nursing* subtitled: "Nursing — What It Is and What It Is Not," in *The Art of Nursing*, and elsewhere she projected stated objectives, indicating the kind of behavior to be achieved by nursing students through the educational program.<sup>7,8</sup> Why then are present-day nurse educators so concerned about the objectives in our schools of nursing? Is it because we are required to state our aims by legal or voluntary accrediting bodies? Is it because we have more sophistication about educational practices in other disciplines and are following the crowd? We hope not and believe not.

We believe that this concern emerges from a greater recognition of the fact that the quality of education for nurses today controls the kind of care our patients will receive tomorrow; from a greater understanding on the part of many practitioners of what nursing is and what it ought to be; and from a deeper insight into the relationship of objectives to the total program and the future behavior of the nurse. We are recognizing that objectives need

constant evaluation as Robert Doherty has stated: "Education is not a static thing. Neither subject matter nor method can become frozen for long periods without imposing almost treasonable injustice on coming generations.<sup>1</sup>" For us, the term "coming generations" means both nurses and patients.

Nurse educators who are trying to state objectives as a basis for helping students to learn to give better care to patients seem to be asking such questions as "If I had heart disease, arthritis, tuberculosis, cancer, how would I like my nurse to feel and act? Would I like her to resemble nursing students who say:

It's boring to nurse patients with long-term illnesses. The sum total of this kind of nursing care is routine. Nothing dramatic ever happens.

There is so little satisfaction when you can't see patients improving day by day. Every morning when you go into the nursing unit the patients are still in bed and they certainly are not looking any better.

If I had a choice, I wouldn't work on a service where there are patients who have chronic diseases.

We found that many graduate nurses don't like this kind of service, either. They just wait around in departments where there are long-term patients until there are openings in the departments of their choice.

One graduate nurse likes it, though, because it is so easy. There are not many bed baths. She just has to make some beds.

Or, would I, on the other hand, like her to resemble students in another group who had different objectives, different learning experiences, different teaching, and who reacted in this manner:

It's a terrific challenge to work with patients who have long-term illnesses. Keeping these patients contented and happy and progressing — that's something to put your teeth into.

More than in any other situation we became involved with patients. We were

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so anxious to see them better in every respect, physically as well as mentally, that we wanted to do anything we could to help them.

It was such a satisfying experience because we got a chance to use so many kinds of skills, social and psychological, with the patients.

We learned so much during this experience. Nowhere else is the "patient as a whole" approach so clear and vivid. And learning to be patient and bide your time before doing the many things you think ought to be done but for which the time isn't quite ripe enough — that is something important to learn!

It's the future I keep thinking of and of what could be done in oh! so many ways. Take tuberculosis nursing. Think of what waits to be done — teaching the public, teaching kids in high school, standardizing precautionary measures so that patients who have been in several institutions will accept them. The future is tremendous.

The very terms used in nursing literature in the past decade and a half suggests a growing concern with what nursing is or ought to be. They include rehabilitative nursing, comprehensive nursing, total patient care, creative nursing. They imply that nurses should be able to help patients to restore themselves physically and mentally; that they should understand and be able to meet all the nursing needs of people, specified and implied; that they should understand the relationship of facts to each other and to action; that they should work with thought and imagination, interpreting along new lines which they invest with form and character. These concepts hold many implications for nursing education and have real meaning for those who are attempting to identify and utilize objectives.

The thoughtful nurse educator working in a school that says its objective is "to prepare well-rounded nurses for a fine profession" finds little in it beyond the intuitive to guide her or her students toward changes in behavior. She does, however, see in it a need, pointed out by Ole Sand, for moving this statement from the intuitive to the explicit through creative thinking.<sup>9</sup> As a result, much action is taking place in the re-examination of the objectives and in the concomitant reconstruction

of the curriculums of educational programs in nursing.

Information gathered through the NLN school improvement program reveals that many schools had no stated objectives in 1951. Since then, their faculties have been working continuously to identify and state objectives in clear and meaningful terms. Objectives of some schools, that have been gathering dust since the late Nineteenth Century, have been unearthed and scoured and are in process of being made useful. The objectives of other schools are undergoing systematic study because they are fundamental to research that is being done on the curriculum. For instance, the faculty of the University of Washington School of Nursing, involved in such research, found that some objectives were suitable and were being stressed sufficiently; it also found gaps between what students were doing and what they should do to meet the demands of society.

Faculties like the one at the University of Washington are in a more fortunate position than most. Generally speaking, the nurse leaders and teachers are better prepared for this job academically and by experience than are the faculties of many of our hospital schools; the students can readily be given opportunity to become involved in a cooperative relationship in the study of curriculum. Resource persons from other disciplines may be more easily available. There is money to support the project. The climate of the university is favorable.

This is not to say, however, that success along these lines is limited to the university schools. As an example, the procedure followed by one hospital school may be pertinent: What all those involved in the educational program thought and what they did and are doing about the program and its objectives can be traced in the minutes of meetings of the faculty, the student organization, the school advisory committee, and the board of trustees. This work was begun because the accrediting board which received the school's application for temporary accreditation in 1952 made the following statement among others:

The philosophy and purposes of the school are not clear; they appear limited

in the scope necessary to help students to meet the nursing needs of patients in our society; they are not educationally oriented; there is little evidence that they are used as guides for program planning; they have not led to the development of more specific objectives for the curriculum.

The statement thus criticized read as follows:

The school aims to give good service to patients; through this students develop skills and interest in nursing as well as personal satisfaction.

This had been formulated by a former director of nursing. Strange as it may seem, the faculty had never studied the statement although about half of its members were fairly well prepared. Neither students nor others concerned with the school had given it any thought. There were no curriculum objectives. From reports contemporary with this statement it appeared that the main emphasis in teaching was to give information and provide the practice of procedures with little relationship between the two. The main emphasis for the learner was on memorization and drill. Examination scores were passing, but the students' behavior with patients was largely directed toward getting things done for them and to them with dispatch and skill. One comment on student performance reports appeared rather frequently, "Student is not interested in nursing, too anxious to get off duty." From this it can be concluded that some students at least were not developing interest in nursing and gaining personal satisfaction from it.

The associate director for education, with the approval of the director of nursing, the hospital administrator, and the board of trustees, helped the faculty, which included both full-time teachers and instructor-supervisors, to become organized into a study group. A resource person in group dynamics was paid by the hospital to help the group to be productive during meetings. Schedules were arranged so that one-half day each week was set aside for meetings. Initial discussion centred, not around objectives, but around what was good and what was poor about the care students were giving, what their attitudes were, and what might be the causes of their behavior. In

other words, an attempt was made to identify whether changes were occurring in the behavior of students through education, what these changes were, and if they were desirable from a social and professional point of view.

A bibliography of references for required study by the faculty was accepted. It included references from general education, the social sciences, and nursing education. The group recognized the need for deliberation and the need for action. At intervals the following statements representing consensus emerged. Some of them are direct quotes and some are paraphrases from literature.

1. The ideas we hold about life and education as a part of life represent our philosophy which strongly influences what we strive for — our objectives.

2. Our objectives influence and should guide what we do and how we go about doing it.

3. In formulating and evaluating our statement of objectives, the criteria stated by Tyler<sup>10</sup> shall be used:

- a. Objectives should be formulated and serve as a guide for appraising and improving the program.

- b. Objectives shall be stated clearly.

- c. Objectives should have significance for work and living for the learner.

- d. Objectives should be realistic and attainable for a program of this type and length.

4. The understanding and support, financial and otherwise, of the hospital board, advisory committee, doctors, and nursing service personnel are needed if proposed changes are to be made.

5. It is especially important that everyone *accept the student primarily as a learner rather than as a worker*. We recognize that while she learns she will give service which is of value, but it is a by-product of learning.

6. The primary purpose of education is to bring about desirable change in the behavior of students.

7. Objectives will emerge one by one and will need frequent revision.

8. Curriculum objectives will be thought about as each objective is formulated. They will help the student to understand more specifically the behavior she is to achieve.

9. Changes in the curriculum shall be thought through as each set of objectives is formulated; we should consider con-



tent, method, sequence, and also if we are prepared to teach what we think should be taught. Not all parts of the curriculum may need to be changed.

10. The students will be asked to study and discuss each objective in a separate group and with the faculty.

The group has implemented these statements, some more effectively than others. The statement of philosophy and purposes in 1955 reads:

We believe each individual student enters the school with individual adjustments to make; that through education she can be helped to adjust happily to new situations, to become self-directing, and to understand and accept her responsibility to society as a citizen and professional nurse.

Therefore, the school aims to prepare qualified young men and women to function effectively as professional members of the health team giving skilled and intelligent care including health teaching to the sick in homes and hospitals.

Some of the content of the curriculum is changed. Some has been added, some deleted, some put in different sequence. Teaching methods have changed. There is less lecture, more use of conference, greater effort to correlate theory and practice. Students spend less time in formal classrooms and more in conferences in patient areas. There is more emphasis for the learner on problem solving.

A few remarks from the diaries kept by students give a clue that the objectives have meaning for them.

Miss X gave me some additional references which really helped me to understand what to do about Mr. Jones. Miss X knows I'm slow but always manage to "get there" eventually.

The class has voted to volunteer to assist with the drive for funds for the Heart Association. I'm glad we worked out a plan for interpreting this problem correctly and objectively to those we approach.

I think I really understand the importance of being able to communicate by word and body posture now. Teaching Mrs. T. about her salt-free diet when she understands nothing but Turkish has really been a challenge, but I feel good about it. We've used pictures, diagrams, demonstrations. For two days she has selected the right foods. She's very intelligent and charming in any language.

Other schools are making similar progress in the statement and use of objectives. Schools working together in the Councils of Member Agencies of NLN are helping. During the past year or two, schools enrolled in the council have been studying and validating the work of committees which are formulating more definite criteria for different categories of schools.<sup>4</sup> Included in the work of these committees is an attempt to define the behavior that would represent the minimum acceptable for the graduate of the diploma program and to differentiate it from that of the graduate of the collegiate program. Studies are being made by nurse educators. The work of Kakosh and Kreuter, for example, is directed toward identifying behavior that might be considered characteristic of the fully professional nurse. Mrs. Kreuter suggests that there are elements of professionalism in the care given by all types of nursing personnel, but that all schools cannot aim to prepare students with the full range of professional behavior. These ideas could help hospital schools as well as collegiate schools to determine the limits of their objectives.<sup>2</sup>

Needless to say, there are barriers to progress in the development and use of objectives and to concurrent improvement in nursing education. If one reads the Weir Report,<sup>11</sup> the articles in *The Canadian Nurse*, such as "The Evolution of Nursing Education," and American publications dealing with similar subjects, it seems reasonable to conclude that these barriers are common to both countries in varying degrees. Reports on both sides of the border dealing with the shortage of leaders in nursing who are prepared to make an analytical and scholarly attack on the barriers may account in large measure for their persistence. However, individuals and groups inside and outside the profession have identified the following as some of the barriers.

Those who are responsible for and control schools of nursing, those who teach in them, and those who are in nursing service do not always apply to these schools the same concepts of a school and, especially a professional school, as they would to other school. They accept the fact that other schools



are established to serve the needs of the learner and recognize that the learner needs time to achieve the objectives. Florence Nightingale said in speaking of schools of nursing, "There shall be an organization which, in giving proper help, gives probationers time to do their work as pupils," that is, the school is organized to serve the students.

This is not always the case. How can the student assigned six or seven patients to be washed, fed, dressed, irrigated, medicated, ambulated, recreated, find time to do her work as a student which includes purposeful thinking, feeling, and acting?

If the school of nursing is really a professional school, then it assumes the great responsibility of giving its students time and opportunity not only to recognize but also to understand and accept the obligations to society which are incumbent on the professions.

Some hospital schools have shown a tendency to become fixed in a pattern without regard for the original purpose which governed this pattern. The same subject matter is repeated in the same way year after year. Students nurse diseases and conditions — cholecystectomies, coronaries, depressions — not patients, each one of whom is different and has different needs. Students are assigned to night duty in the first year because it is supposed to be maturing. Is that really the reason for this practice or is it because that is the easiest way of solving a nursing service problem? Aren't nursing service and nursing education each of enough importance to warrant the best solution rather than the easiest one? Isn't the safety of our patients important enough to have them cared for by nurses who have had time to develop judgment through knowledge and experience? When we do these things do we really believe that we will help to develop creative nurses? Will these students be bored automatons or will they more nearly resemble the students in the second class noted above?

Finally, the actual job of identifying and stating the educational objectives for students and developing a program through which these may be achieved is usually given to the specialists in nursing education. However, it seems

important for others to be concerned with them. Interest and appropriate assistance is needed from those who control the school, from nursing service personnel, from allied professions so that nursing educators will not be out of touch with reality and off the track. It seems important for these groups to understand the objectives and program if they are to be expected to support them. Indirectly, the objectives of our schools are of most importance to our patient who has a right to nursing care by nurses who can meet not only the challenges of today but also those that will emerge in the future.

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## The Bifocal Approach

ADELAIDE SINCLAIR, M.A., LL.D.

**Y**OU HAVE THE ADVANTAGE of belonging to a profession which has long been accepted as both suitable and respectable for women. In this you have the advantage over certain other groups into which women have literally had to force their way and in which they have been both unwelcome and suspect.

I am sure that when you are addressed by someone outside your own profession they never fail to refer to Florence Nightingale. In order not to disappoint you I looked at a recent volume of her life and letters and I shall always be glad that I had occasion to do so. It is a fascinating account of an extraordinarily able woman whose interests ranged far beyond her work in the Crimean War with which she is usually associated. Her pen was both vigorous and uninhibited. There were two comments I could not resist which show the progress which your profession has made in one century.

No man, not even a doctor, ever gives any other definition of what a nurse should be than this "devoted and obedient." This definition would do just as well for a porter and it might even do for a horse.

There is a commonly received idea that it requires nothing but a disappointment in love or incapacity in other things to turn a woman into a good nurse.

Just in case you should be feeling complacent about your professional status, I shall give you one other ex-

cerpt that I came across recently in an account of a program to set up rural health centres in Iraq. In order to provide the personnel for the centres a one year's training program was organized in Bagdad but it was found necessary to describe those taking the course as "trainee social workers." They could not be called nurses because "that is a profession still considered as being on the level of domestic service."

Tonight, I want to use what I heard described recently as a *bifocal approach*. Much of your time at this convention must properly be spent in looking through the lower half of your mental spectacles at your immediate professional problems. I hope you will now raise your eyes and look through the upper half at wider and more distant horizons and consider some of the needs which confront nations today. An exercise of this kind in addition to giving you a wider view may also help your perspective when you go back to the lower half of your bifocals.

In selecting certain needs to bring to your attention, while I have tried to choose those that might be of interest to you, I have made a broad selection on the basis of needs that concern all mature and responsible citizens.

The needs of a nation vary depending on its stage of development. I shall first deal with those nations that are known in the international vocabulary as "underdeveloped."

These represent, unfortunately, a very large proportion of the world's people. Because isolation and indifference are no longer possible it is important that we should be aware of their problems. Most of them are fac-

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Mrs. Sinclair, who is executive assistant to the Deputy Minister of National Welfare, Department of National Health and Welfare, presented this address during the 28th Biennial Convention.



ing a vicious circle of disease, ignorance and poverty which they are striving to break. In many of these countries life expectancy is less than 30 years. Compare this with the Canadian figure in the high 60's.

A year or two ago my Department had a visit from the Minister of Health for India, Rajkumari Amrit Kaur. She is a most fascinating woman. In describing the health problems of her country she said, with justifiable pride, that within recent years the life expectancy in India had been raised from 26 to 30 years. When you consider that the population of India is between three and four hundred million you will realize that this is no mean feat.

Another index is the infant mortality rate. Compare Sweden's which is 20, with 200 which is not uncommon in underdeveloped countries. In some local areas it is believed to run as high as 300 or 400. Consider the ratio of nurses to the population. In Canada, we have 1 to 286, in the Philippines there is 1 to 5400 and in India, there is 1 to 55,000.

Many of these countries are subject to ravages of diseases, such as malaria, tuberculosis, yaws and trachoma, that take their toll in death and disability every year. Impure water supply and poor sanitation lead to many gastrointestinal diseases. Malnutrition is another serious problem, whether it results from insufficient food or ignorance of how to use existing food supplies.

It is estimated that at least half of the world's population is illiterate. One result of this is the great lack of trained personnel in all fields. This is often more serious than a lack of funds because unless there are people available who can properly utilize supplies and equipment these are of little use. The staff shortage in the health field is so great that many mothers are attended by no one except untrained village midwives.

There are, however, two encouraging factors in what could admittedly be a very gloomy picture. One of these is that the apathy and resignation which used to be characteristic of many of these countries are disappearing. There is an increasing desire among these people to raise their own stand-

ards and an awareness that this is possible. The second is that international assistance of various kinds is available to help them in their efforts. I should like to give you a few illustrations of how this is being utilized. The World Health Organization and the United Nations Children's Fund have many joint projects in the health field. The Children's Fund uses its resources to provide supplies and equipment while the World Health Organization supplies the technical advice and personnel. This latter, of course, includes a large number of nurses.

New drugs make it possible to conduct mass campaigns against some of the more prevalent diseases at a minimum cost. For example, in the field of prevention, BCG vaccine has been used against tuberculosis. It is safe to say that the work in the last eight years probably represents the largest mass health campaign ever undertaken in the world's history. Over 160,000,000 children have been given tuberculin tests. Those with a negative reaction, somewhere about 50 per cent have been vaccinated with BCG. It is not possible to estimate how many children have been spared tuberculosis by this means but the numbers must be very substantial.

Top priority is being given to campaigns to eradicate malaria. Spraying at the appropriate time of year with DDT has destroyed the mosquitoes and reduced the incidence of malaria. The spraying did not require a high degree of skill so it was possible to conduct this campaign with a minimum of expense. A great improvement was brought about in many of the most serious malarial areas in the world. In recent years, investigation has proved that the mosquitoes were not without resources and that they were developing a resistance to the DDT. If this continues there was reason to fear that the whole problem might flare up again. The only answer seemed to be the complete eradication of the disease before the mosquitoes' resistance to DDT became established. This has meant a much more intensive and complicated campaign because the work had to be carried into every village where there was even a trace of malaria, for any residual pocket



of infection could re-infect the whole community. It is, of course, possible that man will prove to be no less resourceful than the mosquito and may invent a new insecticide against which resistance will not be built up. Until this occurs top priority is being given to assisting countries with eradication campaigns.

While it is sound therapy to promote prevention, there are also campaigns that attempt to cure existing diseases. One of the most horrible infections of tropical areas is yaws which infects whole villages with terrible sores that cripple rather than kill the juvenile population. For centuries it was assumed that nothing could be done about this but with the advent of penicillin it was discovered that most cases of yaws could be cured with a single shot — only the more obstinate ones requiring two or three. This made it feasible, financially, to undertake an active campaign. It required the cooperation of the whole community to be sure that all the cases were mustered when the visiting team arrived. First, the head man of the village had to be persuaded. In one part of Indonesia, the children were induced to come because they were invited to a party at which an old Tarzan film was shown. There was no admission fee but no child was allowed to see the film until he had been examined and, where necessary, had had his shot of penicillin. Many countries can definitely look forward to the prospect of eliminating yaws within 5 or 10 years.

Trachoma, if not treated, frequently leads to blindness. At the moment there is no easy one-shot treatment. When requests for assistance were received there was a fear that it would be impossible to organize successful campaigns which required several treatments a day over a period of months. Here again the experiment has succeeded far beyond what had been hoped. By enlisting the aid of school teachers, who agreed to supervise the programs, tremendous improvement has been made in areas such as Taiwan and North Africa where the experiments have been undertaken. Children are being trained to persuade the older members of their family to have treatment at home.

As these mass campaigns developed in various countries it became obvious that there is a real need to build up the basic health services in the rural areas where about 80 per cent of the population live. International aid is also being channelled to assist in this development. In this field, many Canadian nurses have played a very important part.

One of the basic principles in all these international programs is that the aid is given to assist countries in developing their *own* services and is only given at their request. The receiving countries have, therefore, the responsibility of making the plan and undertaking the local organization through which foreign supplies and personnel are channelled. It is understood that when the initial period of assistance is over the countries themselves will continue the work with their own funds and their own personnel as part of their regular health services. There is now ample evidence that the countries that have been aided are both able and willing to continue the programs.

In all of these developments for which assistance is sought there is need for more than skill and efficiency. These problems must be approached with imagination, with sympathy, with flexibility and with respect for the existing cultural patterns. When one is asking a people to change a way of life that has prevailed for centuries it is nothing short of a revolution. Many of these new techniques and remedies come with a sudden impact that we in the western countries, where they have come gradually, have never known.

Where women are in "purdah" as in many of the Muslim countries, it takes courage to emerge into the world of everyday affairs. In Afghanistan, women in seclusion may not be treated by a male doctor, yet in the whole country a few years ago there were only two women doctors — foreigners — and they were in the capital, Kabul. In certain parts of Asia no woman may be treated by a doctor who is younger than her husband. Whatever we may feel about these customs the fact remains that they are a very real part of the society in which they prevail and cannot be lightly set aside.

We do not yet know what this sudden impact of modern techniques on comparatively primitive society is going to do to that society but it is bound to have profound effects. It will need great understanding on our part to help with the transition.

When we come to the so-called developed countries the picture changes. Many of the more obvious needs have been met, many diseases have been eliminated or are under control. We have sanitation, we have pure water supplies, we have a reasonable supply of food and in most cases we have free public education. Industrialization has raised our standard of living but it has brought with it new problems. One of these is large urban concentrations of population which brings new health problems and creates shortages of housing. In this latter field we still have a long way to go and perhaps have lessons to learn from other countries.

Bombay has an interesting law on housing. They recognized that as large industries attempted to establish themselves in the city they would undoubtedly attract large numbers of people from the rural areas to work in their plants. As housing was already acute, a law was passed requiring any new industry that wished to locate in Bombay to provide housing for the number of people they wished to employ before they began operations. This was a very sensible way of profiting by the mistakes that have been made in western industrial countries.

The stresses and strains of an industrial society and its tempo have brought their own toll of mental illness. Since improvement in health has brought greater longevity, we are confronted with many problems of the aging population which are nonexistent in less developed countries. I recall a very interesting conversation that I had with a visitor from Pakistan who confessed himself as frankly shocked at our treatment of old people. He explained that in his society it would be considered a disgrace if the older members of the family were looked after by the community, that this was a family responsibility which should be assumed with both pride and pleasure. He thought it indicated a degree of materialism in our society that we

expected the state to provide pensions, medical care, housing and other facilities for old people. While I agreed that we have developed a considerable degree of materialism in our society, I tried to explain that there might be circumstances which made this pattern both more understandable and more justifiable than he felt it was. To begin with, because of our longer life expectancy the problem of old people has reached greater proportions in Canada than it has in Pakistan. It is not uncommon here for a family to have four grandparents living. Housing facilities, particularly in urban areas, no longer permit the inclusion of all the older members of the family. The greater mobility of our population means that families frequently are scattered and unable to provide personal care and shelter for parents and grandparents.

Family responsibility provides no solution for numbers of old people who are completely alone without any close relatives. As a result of the size and nature of the problem we have now reached a stage where we accept the fact that the community as a whole has a responsibility for these people. This might be regarded as an extension of the family conscience to the state. Perhaps it is not a backward but a forward step.

The last need to which I want to refer, is one of which we are becoming increasingly aware — the necessity of recognizing that man is a whole person. Because of our increasing knowledge and resources our society has tended to produce specialists in narrower and narrower spheres. In addition to many new professions which have developed in the past 50 years, we have tended to establish rigid categories within professions. We have to face the fact that this has created a number of vested interests, a fair amount of professional jealousy and a tendency to make mysteries of the particular tasks that we perform. This has reached a point where we have been compelled to recognize that these water-tight compartments are not always beneficial to the people that the professions are supposedly trying to serve. A whole person has a variety of needs — health, nutrition, shelter, education, recreation, employment, spiritual and mental satis-



faction. To be of help in one area, it may be very important to have a knowledge of needs and resources in other areas and to secure the assistance of the experts in those fields. More and more we are becoming aware of the value of teamwork for which we have invented a high-sounding phrase — the multi-disciplined approach. This need for teamwork is perhaps a good one on which to end.

There are, of course, many needs that only nurses can meet but there are also many ways in which you can, if you have the will, fit into the larger

pattern of the helping professions. The plea which I would make is that you do not neglect, from time to time, to look through the upper half of your bifocals to the larger needs of the world so that you, with many others, may justify the faith that Arnold Toynbee has expressed when he said that "the Twentieth Century will be chiefly remembered not as the age of political conflicts or technical inventions, but as an age in which human society dared to think of the welfare of the whole human race as a practical objective."

## K. P. for Double-Duty Homemakers

LOUISE PRICE BELL

**M**ANY HOMEMAKERS OF TODAY run a home and hold down a nursing job as well. Doing both things well is a challenge, but the duties can be made to dovetail in an efficient manner if the planning is sound. System is important in homemaking. When homemaking and career are combined, system is something to be really considered!

Allow time enough in the morning for a nourishing breakfast eaten in an unhurried manner, if you want to start the day right for both bread-winners. To assure a pleasant homecoming at night either wash the dishes, stack them neatly, or pack them in the dishwasher. This will take very little time and means less work at night. If possible, make the beds, too, as coming home to an orderly house does much for that late-afternoon slump.

Most working couples get their lunches away from home, so breakfast and dinner are the main considerations. Your day off can be "marketing day," and the time to stock up on the things you will need during the week. Store staples in a cupboard, vegetables and fruits in the refrigerator, frozen foods in the home freezer. Knowing that you're "set" for a week gives a feeling of satisfaction. You can whip up a dessert or two, a gelatin salad, and perhaps a casserole for baking

early in the week. If you like to cook, you can even concoct things to store in the freezer against the unexpected arrival of an old nursing pal.

Tastes vary; people have different likes, allergies, and peeves regarding food. As the homemaker, you should work out the menus or stock meals that you know from experience are satisfactory. Having a few of these on tap, or having the ingredients to make them, will mean that you can quickly prepare and serve them. Good springboards for any meal are easily-prepared foods that you have done over and over so that there is little chance of failure. Suppose, for example, your chili wins applause every time you serve it . . . With greens in the refrigerator, Melba Toast and crisp crackers in the cupboard, and frozen broccoli in the freezer, you can serve fresh fruit for dessert and feel that the meal is a well-balanced one that is sure to please.

A rib-sticking dinner that men like is roast pork, baked in a nest of sauerkraut, with potatoes getting done to a turn with the same heat. All you need with this is a green vegetable and a salad, with perhaps a tomato juice starter and a fruit and cookie finish.

Baked beans and brown bread are hearty, and flanked by cabbage salad with sour cream dressing, raw carrots,

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Mrs. Bell resides in Tucson, Arizona.

*(Continued on page 894)*



# Hydrocephalus

JOANNA JENKINSON

## SOCIAL BACKGROUND

Little Vickie, an 8-month-old, 22 pound baby girl was admitted to hospital in May, 1955 and placed under observation for hydrocephalus. She was the second of two children, the first of which — a 3-year-old-girl — was normal in all respects.

## MEDICAL BACKGROUND

Vickie was born in September, 1954, after a somewhat difficult labor. Her weight at birth was seven pounds. Her mother stated that neither she nor the attending physician considered the baby's head to be unusually large at the time of delivery. Previous to admission, the baby had taken her feedings well, and had gained weight normally. There had been no unusual vomiting or fretfulness but there was a tendency to constipation. Past medical history revealed only the occasional cold which was insignificant in making a diagnosis. The principal concern had been the rapid enlargement of Vickie's head.

## GROWTH AND DEVELOPMENT

In the field of growth and development, Vickie's progress had been close to normal being hindered mostly by her heavy, immobile head. A child of eight months should be sitting alone, creeping on all fours and beginning to pull herself up alongside furniture. Because of her heavy head Vickie was confined to a supine position.

Her dentition was almost normal. Her four central incisors — two upper and two lower — were in place and the left lateral upper incisor was also present. The only deviation from normal here was the absence of one upper lateral incisor normally present in 8-month-old infants.

A baby of this age is, as a rule,

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Miss Jenkinson was a second year student at St. Joseph's Hospital, Victoria when she carried out this study.

drinking from a cup. Vickie was unable to do this but took pureed foods and cereal well by spoon.

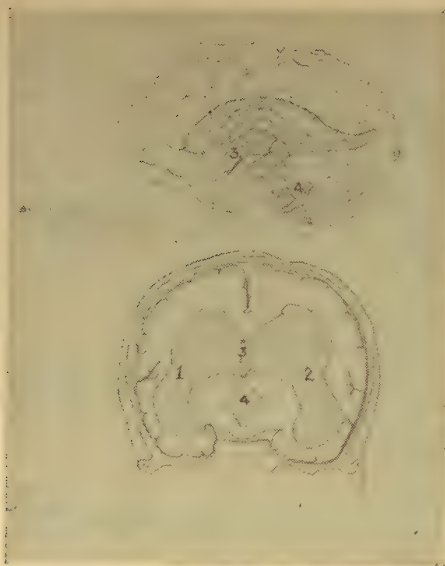
## PHYSICAL EXAMINATION

The general physical examination showed nothing unusual except the very obvious abnormality — the greatly enlarged head. The child's head was 52½ cm. at its greatest circumference and 35 cm. from ear to ear. The enlargement of the head was in its uppermost portion and the cranial sutures could easily be palpated. The fontanel was tense. The forehead was bulbous and the eyes protruded in the manner characteristic of hydrocephalus. Neurological examination was negative. Vickie moved all extremities well, appeared to be alert, and behaved in a fairly normal manner except that she was unable to move her head freely. A provisional diagnosis of hydrocephalus was made pending further investigation.

## HYDROCEPHALUS

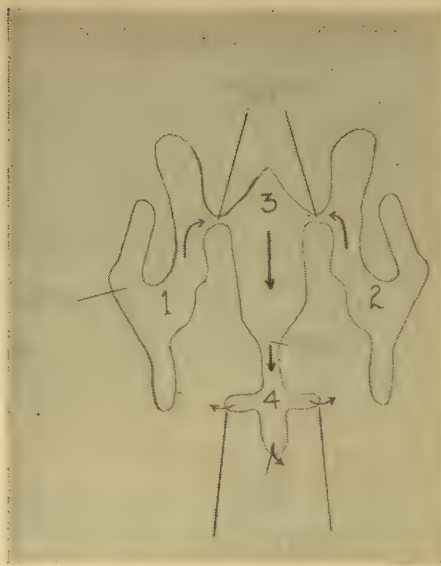
Briefly, this is a condition in which the amount of cerebrospinal fluid is increased greatly above normal. It results in an increased size of the head and characteristic pressure changes in the brain.

Normally there is a delicate balance between the rate of formation and of absorption of the cerebrospinal fluid. The entire volume is absorbed and replaced once every 12 to 24 hours. The fluid is secreted primarily by the choroid plexuses in the lateral, third and fourth ventricles of the brain. As far as can be determined, there is limited secretion from any other source. The choroid plexuses are highly vascular folds or processes of the pia mater in the ventricles. From the lateral ventricles, the fluid flows through the foramina of Monro, the third ventricle, thence through the aqueduct to the fourth ventricle. Here it escapes through the roof of the foramina into the cisterna magna and



A. A scheme showing the normal relations of the ventricles to the surface of the brain.

B. Section through the brain showing marked dilatation of the lateral and third ventricles in Hydrocephalus.



C. Ventricular scheme showing the route of flow of cerebrospinal fluid from the lateral ventricles (1, 2), through the third ventricle (3) (foramina of Monro), the aqueduct, and the fourth ventricle, from where it escapes through the foramen of Magendie.

then up the basilar cistern beneath the pons through the opening in the tentorium into the subarachnoid spaces. From there it passes around the cerebral hemispheres to the arachnoid villi of the sagittal sinus. Although there are other areas of absorption present the process is accomplished chiefly through these villi. For all practical purposes, unless there is adequate absorption into the sagittal sinus, the balance between the secretion and absorption of fluid will be altered and a state of accumulated cerebrospinal fluid or hydrocephalus will develop. The problem of the surgical treatment of hydrocephalus begins with the study of the secretion and absorption of this fluid.

#### CLASSIFICATION

**Obstructive Hydrocephalus:** This classification implies that there is an obstruction or block to the normal flow of spinal fluid somewhere in the ventricular system. It produces an accumulation of fluid within the system and increased pressure with dilation of the ventricles themselves. Possible causes may be congenital or acquired abnormalities.

**Communicating Hydrocephalus:** This is a state in which there is a free flow of cerebrospinal fluid within the ventricular system to the subarachnoid pathways over the spinal cord and surface of the brain. The defect in normal cerebrospinal fluid physiology in this condition is one of reabsorption. The disturbance in absorption — the most common cause of hydrocephalus — may be classified as follows:

##### A. Those of *congenital origin*:

Failure of the foramina to become patent.

Disturbances in the development of the aqueduct.

##### B. Those of *infectious origin*:

Congenital infections, toxoplasmosis, etc.

Meningitis, either acute or chronic, with secondary fibrosis and obliteration of the cisterna or subarachnoid channels.

Chronic arachnoiditis of unknown origin.

##### C. Those of *vascular origin*:

A cerebral hemorrhage at birth may block some of the channels. The reabsorption of the blood may be associated with fibrosis which may lead to permanent obstruction to the flow of cerebrospinal fluid.

#### D. Those of *neoplastic origin*:

In general, hydrocephalus is more likely to occur where the tumors are adjacent to some of the foramina.

#### E. Those of *unknown origin*:

This is a group with a communicative type of hydrocephalus in which no specific pathology has been demonstrated. Various causes such as fetal meningitis have been suggested but none have been proven.

### SIGNS AND SYMPTOMS

In many cases of congenital hydrocephalus the child dies in utero. At other times the process may be so far advanced before birth that Caesarean section or craniotomy may be necessary before delivery is possible. In perhaps the majority of cases, no symptoms — as in Vickie's case — are apparent at birth or the head is only slightly larger than normal. The signs and symptoms of the condition are usually manifest when the child is two or three months old. Vickie presented a typical picture.

The first noticeable sign of the condition often is that the head is increasing in size at an abnormal rate. Instead of the customary half an inch a month, it may be two or three times this. If the progress is rapid, other symptoms are soon evident. The infant cannot hold up his head; he is lethargic; all his perceptions are dulled. Only in rare cases is there blindness but there is usually some interference with vision. This is difficult to check in small infants. The pupils are equal, though they may be dilated. Nystagmus and convergent strabismus are often present. In severe cases the great weight of fluid distorts the roof of the orbit by pressure from above, pushing the eyes downward and causing them to protrude slightly, so that some of the sclera is visible above the cornea. Due to tightness of the scalp the upper eyelids are pulled up. This further exposes the cornea and gives the characteristic expression associated with exophthalmus. Optic atrophy of greater or less extent accompanies severe cases. Very rarely is there deafness. There is usually rigidity of the muscles of the extremities.

For a time nutrition is well maintained but when the head enlarges

markedly the body wastes. The disproportion between the two may seem more marked than it really is. Convulsions sometimes occur. Cases which develop early and progress rapidly are usually fatal before the end of the first year and frequently before six months. The usual termination is from nutritional failure frequently associated with infection and anorexia. Cranial bedsores develop sooner or later. In some instances this may lead to pressure necrosis of the skull and a terminal meningitis. Intelligence is usually impeded. The veins of the scalp become distended due to the drainage of intracranial circulation through emissary veins into the peripheral circulation.

All these symptoms were markedly noticeable in little Vickie. It was very depressing to nurse her as her condition progressed rapidly.

### LABORATORY TESTS

When Vickie was admitted to hospital, the usual routine urinalysis was done. This proved normal in all respects. Routine hematology indicated a normal blood picture.

Wassermann and colloidal gold tests done on the cerebrospinal fluid were negative. The Wassermann test was done to determine the presence of congenital syphilis. The colloidal gold test is specific for increased protein which would be indicative of meningeal infection.

### X-RAY REPORTS

Reports from the first x-rays taken of Vickie's skull indicated that there was considerable enlargement of the cranium with marked prominence of the convolutionary impressions which indicated hydrocephalus.

Phenol red was injected into the right lateral ventricle and within a half-hour a lumbar puncture was done. The cerebrospinal fluid obtained was distinctly colored. This was a good indication that the type of hydrocephalus being dealt with was communicative and the problem faced was one of reabsorption.

### VICKIE GOES TO SURGERY

In June, Vickie made her first trip



to the operating room. In preparation for this both sides of her scalp were shaved the morning of the operation. Her blood was grouped and cross-matched.

Preoperative sedation consisted of morphine gr. 1/200 and scopolamine gr. 1/300 one hour before operation, and 10 cc. of 2% sodium pentothal by rectum twenty minutes previously.

*Morphine* — depresses the sensory and psychic areas of the cerebrum thereby quieting the patient and making anesthetic induction easier. Respirations should be checked as morphine depresses the respiratory centre in the medulla giving slower and shallower respirations. The heat regulating centre is also depressed and diaphoresis may be present. The patient should be kept warm and free from draughts.

*Scopolamine* — decreases the secretion of saliva and mucus in the nose, pharynx and bronchi, thus leaving the mouth and air passages dry. This reduces the hazard of aspiration. It also favors the absorption of the inhaled anesthetic agent.

*Sodium Pentothal* — a rectal injection of 2% sodium pentothal was given for further sedation. This made the child more manageable and reduced the amount of inhaled anesthesia required. Later, in the operating room, the only anesthetic needed was an additional 4 cc. of sodium pentothal by rectum.

The operative procedure was a ventriculogram, which is a process of injecting air into the cerebral ventricles. It was used to determine the degree of dilation of the ventricles. A lumbar puncture needle was inserted into each lateral angle of the anterior fontanel. Clear ventricular fluid issued under increased pressure from each needle. Stilets were withdrawn and oxygen was introduced into the ventricular system as the cerebrospinal fluid ran out. In all, 400 cc. of oxygen were injected. At the close of the injection a few minutes were allowed to elapse so that the intracranial pressure was just about the same as, or a little less than it had been, at the beginning of the procedure. The needles were withdrawn and the patient removed to the x-ray department for films.

X-ray reports showed the entire ventricular system to be grossly dilated. This dilation was most marked in the

anterior horns. As a result, the cerebral tissue was becoming compressed into a thin shell lining the cranium. The air passed readily through the ventricular passages to the cisterna magna and pons, but failed to infiltrate the remainder of the subarachnoid space. These findings indicated a communicating hydrocephalus, presumably of congenital origin.

## NURSING CARE

Now that the diagnosis of hydrocephalus was confirmed, Vickie's nursing care became a challenge. As is usually the case with hydrocephalics, Vickie was a feeding problem. She vomited approximately every second feeding during the first part of her confinement in hospital although there had been no evidence of this while she was at home. She also appeared to have some trouble suckling. The maintenance of her nutritional status was most important with the pending major surgery. It was found that she had less trouble in keeping down solid foods, such as pabulum and pureed fruits and vegetables, than she had with her formula. In spite of this feeding problem, Vickie did not lose weight.

The second major problem faced in nursing little Vickie, and which is present in the nursing care of every case of hydrocephalus, was the prevention of pressure sores on her heavy immobile head. Her head had reached a size where she could not hold it up nor could she assume a sitting position without her head being supported for her. It had to be moved for her frequently to prevent pressure sores. The scalp was given particular attention in so far as cleansing and general care were concerned. A foam rubber pillow was used as a preventive measure. It is well to remember that unless the head becomes too enormously heavy, holding the child for feedings will relieve pressure for short periods.

Both before admission and during her entire period of hospitalization Vickie had a tendency towards constipation. This was corrected with glycerin suppositories.

Again Vickie was booked for surgery. This was to consist of a right nephrectomy, a laminectomy, and an arachno-ureterostomy.

## PREOPERATIVE CARE

Because the kidney was to be removed an excretory urogram was done. This was necessary to ensure that the urinary system was functioning properly and that the remaining kidney would be able to carry on. Seven cc. of diodrast (a radiopaque dye) diluted with sterile water and hyalonuridase (for faster absorption) were injected subcutaneously for this examination. The urinary tracts were fairly well visualized on both sides. The structure and function appeared normal; no calculi were evident; the bladder was regular in outline. X-ray films taken of the lumbar and sacral vertebrae showed no osseous abnormalities.

Nothing was given by mouth the morning of operation. At 8:00 a.m. a cut-down was performed into the great saphenous vein in Vickie's right ankle for parenteral administration of fluids. A metal cannula was inserted and an intravenous of normal saline was begun.

One hour preoperatively morphine gr. 1/120 and scopolamine gr. 1/300 were administered hypodermically. Twenty minutes preoperatively, 12 cc. of sodium pentothal were administered rectally. Vickie was taken to the operating room where induction was accomplished with nitrous oxide and cyclopropane.

*Nitrous Oxide* — may be given as a prolonged anesthetic if the gas is used with the necessary amount of oxygen. It is, however, a respiratory depressant and cyanosis must be watched for. Untoward effects on the kidneys, liver, circulation and respirations usually come from oxygen deficiency. It is most frequently used as an induction anesthetic.

*Cyclopropane* — a colorless gas, is administered by inhalation. It is explosive but has a wide margin of safety and oxygen can be given with it. It affords a greater muscular relaxation than nitrous oxide but causes more post-anesthetic nausea. Respiratory depression may come on very rapidly. Danger signals such as slowing of the heart and arrhythmia must be watched for.

At operation a laminectomy was performed in the prescribed location. After the laminectomy was completed the

dura was seen to bulge. At this point Vickie was turned on her left side, and the right kidney was exposed and removed. The ureter at the ureteropelvic junction was sectioned. A multi-perforated polyethylene tube was threaded about 4 cm. down the ureter.

An incision was made in the dura mater and arachnoid mater through which a considerable amount of cerebrospinal fluid was evacuated. The polyethylene tube which had been previously led into the site through the wall of the laminectomy incision, was cut long enough to allow a small loop to be formed. The end of the tube was prepared with additional lateral perforations and was introduced into the subarachnoid space for a distance of 5 cm. Here it was securely fastened and the dura mater was pulled tightly around it at the point of entry. The laminectomy incision was closed in routine fashion. Before Vickie left the operating room, 1.5 cc. of phenolsulphonthalein dye was injected into the right lateral ventricle.

In the operating room, 100 cc. of the normal saline which had been attached to the cut-down was absorbed. This was followed by 100 cc. of 5% glucose in distilled water. Subsequently, 200 cc. of whole blood were administered and finally 300 cc. of normal saline were given. This was necessary to prevent a drop in blood pressure and shock. It also combatted dehydration and protected against carbohydrate depletion.

## POSTOPERATIVE NURSING CARE

On Vickie's return to the ward from the recovery room, her color was good and she was apparently in satisfactory condition. The development of the numerous early signs and symptoms of the various postoperative complications were watched for — especially those of hemorrhage. There is always a remote danger of the ligature about the renal pedicle becoming loosened causing internal hemorrhage, following nephrectomy.

Leg restraints were applied to keep the cannula being employed in the cut-down in place in the vein. It was most important that this be kept in good working order. Vickie refused everything offered by mouth and



dehydration during her first few post-operative days was prevented by parenteral therapy. Vickie was kept warm. Her position was changed frequently to prevent hypostatic pneumonia. Dressings were checked frequently for oozing from operative sites. Temperature, pulse and respirations were observed closely.

Achromycin 25 mg. was administered intramuscularly twice daily as a prophylactic measure and aspirin gr. 5 was given q.4 h. for pain. It was important to remember that Vickie could not tell us when she was having pain. To prevent any that might occur, the aspirin had to be given on schedule. Neither could negligence be afforded in the administration of the achromycin as Vickie's meninges had been open thus affording an easy portal of entry for infection.

An order was left to save urine specimens and to record the time of collection of each. This was in order to estimate the amount of cerebrospinal fluid which was being excreted via the arachno-ureterostomy. It was for this purpose that the phenolsulphonthalein dye had been injected into the right ventricle following operation. Several urine specimens, sent to the laboratory for P.S.P. content, gave a negative response. This meant that somewhere along the way from the subarachnoid space to the ureter there was an obstruction to the flow of cerebrospinal fluid.

Vickie was scheduled for a revision and re-exploration of the arachno-ureterostomy. The operative incisions made previously were reopened and the cause of the obstruction was immediately apparent. The polyethylene tubing had developed an acute angulation at one point although it had been so directed that there was no acute curve at the time of the previous operation. A second piece of reinforced polyethylene tubing of the same size was substituted.

Urine specimens were again kept and sent to the laboratory for determination of the amount of cerebrospinal fluid being eliminated with the urine. Reports from the laboratory showed that a total of 8% of the P.S.P. dye had been excreted. This was a

good sign that the operation had been successful.

The cut-down was kept open with solutions of glucose and saline until July at which time it was felt that Vickie was taking fluids well enough by mouth to prevent dehydration. Her formula was fed to her by spoon, as she still appeared to have trouble suckling. It was important to realize that dehydration could also be caused by depletion of the body's supply of salt. As it was evident that a good share of this was being lost in the cerebrospinal fluid which was being excreted in the urine, sodium chloride gr. 15½ was ordered, to be given twice daily with pabulum. Vickie's diet was rapidly increased to include meat purees. Tri-vi-sol drops (a vitamin preparation containing vitamins A,B, C in a non-alcoholic solution) were also ordered as a dietary supplement.

Vickie's head appeared to become smaller and bony prominences from overlapping sutures were almost conspicuous, especially those of the coronal suture.

#### PARENT EDUCATION

There was essentially no patient teaching directly involved in this instance. The problem of caring for the child with hydrocephalus in the home was of major concern to the parents. This would involve the same techniques employed in treating the child medically in hospital. Basically, pressure sores had to be prevented and the patient kept as comfortable as possible. Also the parents must be prepared to realize that the child is seriously in need of affection, even more so than the normal child.

#### CONCLUSION

The case study of Baby Vickie, though pathetic, produced a valuable learning experience. The fact that it was the first case of hydrocephalus that I had observed, made it more interesting than it would have been for an experienced person. I feel I may, in future, be able to recognize and care more intelligently for any other similar conditions I may encounter.



# Scarlatine plus Endomyocardite

HÉLÈNE PAYER

## HISTOIRE DE FAMILLE

Fillette de six ans d'une famille de trois enfants dont deux frères, Carole est blonde, a les yeux vifs et est dotée d'un caractère quelque peu masculin. Elle a une prédilection pour les jeux durs et rudes, elle admire ses deux frères et s'efforce inconsciemment de les imiter. Son papa tient une place importante dans sa vie, ses propos nous le prouvent souvent. Sa maman lui est chère aussi, cependant, la tendresse maternelle est quelquefois amoindrie en face des gâteries du papa; réactions psychologiques normales d'une fillette de cet âge. Au cours de sa maladie, on la comble de jouets, ces derniers sont réduits rapidement en pièces. Les plus jolies poupées ne sont pas épargnées, l'instinct maternel n'est pas développé. Carole est brusque et masculine.

Depuis son enfance, peu de maladies contagieuses à noter sauf la rougeole et un impétigo bulleux qui n'a cessé de récidiver; aujourd'hui, c'est une scarlatine contractée dès son entrée à l'école. Mentionnons toutefois qu'elle reçut les vaccins D.C.T. et variole au préalable.

## ANALYSES

*Hémogramme:* dans le but d'obtenir un rapport détaillé de la formule sanguine avec ses modifications dans l'état pathologique présent.

*1er rapport:* Diminution du nombre des globules rouges et augmentation de la formule leucocytaire.

*2e rapport:* Diminution moins marquée du nombre des globules rouges et formule leucocytaire moins élevée.

*Hémoculture:* cette analyse permettant de vérifier la nature de l'agent pathogène est fait à cinq reprises différentes toujours avec un résultat négatif, c'est-à-dire absence de bactéries pathogènes.

Préparée par Mlle Payer, troisième année, Hôtel-Dieu de Montréal.

## Prélèvements:

1. Secrétions du nez et de la gorge sur Loeffler.

*Rapport:* absence de bacilles diphtériques.

2. Secrétions de la gorge sur gélose-sang.

*Rapport:* présence de streptocoque hémolytique.

3. Ulcérations des joues pour frottis de Vincent et culture sur anaérobie.

*Rapport:* absence des organismes de l'angine de Vincent; sur anaérobie, absence de poussée bactérienne.

Ces cultures furent faites dans le but de découvrir les agents microbiens en cause et de permettre l'emploi d'un antibiotique de choix.

## Analyses d'urine:

(P.D.) à deux reprises, vue l'importance de suivre l'état du rein au cours de la scarlatine.

Un premier rapport est légèrement modifié tandis que le deuxième est sensiblement normal.

## Analyses du sang:

1. *Prothrombine:* révèle 64% au début et 87% par la suite. Cette analyse a pour but de déterminer le taux de prothrombine dans le sang, lequel se maintient normalement entre 80-100%.

2. *Hématocrite:* 27%, alors que l'hématocrite normale, c'est-à-dire le volume des globules par rapport au sang total est de 40-47%.

3. *Sédimentation:* 26 mm. Ce test a pour but de connaître la vitesse de chute des globules rouges. Dans certaines conditions pathologiques cette vitesse de chute est augmentée. La normale: 0.15 mm./hre.

## TRAITEMENTS

Sérum glucose 10%, 500 cc. I.V. les deux premiers jours. Sérum béclysyl 500 cc. I.V. le 3e jour et pour 6 autres jours consécutifs.

Ces solutés enrichis de vitamines C (200 mgm.) et B<sub>1</sub> (100 mgm.) compensent à l'insuffisance du régime oral. De plus ces solutés contiennent un antibiotique soit:

Erythromycine 500 mgm. les six premiers jours; soit encore:

Achromycine 500 mgm. le 7<sup>e</sup> jour.

Aux doses de vitamines mentionnées plus haut et administrées par voie intra-veineuse on ajoute de la vitamine B et K en injection et en capsules.

D'autres antibiotiques tels que: Wycillin, Chloromycine, Achromycine-Elixir et Bicillin L.A. furent administrés successivement, à dose massive au début afin de maîtriser l'infection, ensuite les doses furent espacées au fur et à mesure que la maladie regressait. En outre, l'enfant reçut:

Distreptin nasal puis Neo-Cortef en gouttes nasales.

Auralgan dans son oreille droite.

Neosporin sur lésions d'impétigo de la main droite.

Neo-Cortef ophtalmique au début de sa maladie.

*Le repos absolu:* prescription de non moins d'importance.

*Diète:* Lacto-végétarienne pour les 20 premiers jours généreuse par la suite.

En dépit de son jeune âge et de la thérapeutique élaborée dans la présente maladie, la petite Carole coopère d'une façon admirable. Tous les médicaments et solutés sont assimilés sans mauvaise réaction et de jour en jour la maladie regresse. La compétence des médecins jointe à la surveillance minutieuse de l'infirmière acheminent très tôt la fillette vers la guérison.

#### SOINS DONNÉS

Le début de la maladie est insidieux et demande un dévouement professionnel de tous les instants et un nursing compétent. La température très élevée a une répercussion sur l'état mental de l'enfant; ici, on recourt avec succès aux lavements à l'aspirine et aux vessies de glace. La fillette fait preuve d'une certaine force morale et durant les jours critiques, elle ne refuse jamais un traitement, sérum ou injection et accepte de bon gré une diète légère. Son tempérament un peu masculin la rend dure à son corps et à certains moments, il faut lui imposer le repos avec rigueur. D'autre part, son caractère enjoué et son besoin d'ac-

tivité font appel aux principes de psychologie infantine. L'enfant n'est pas désagréable à soigner comme le sont ordinairement les enfants gâtés ou capricieux. Les infirmières s'attachent vite à elle et suivent avec joie l'évolution heureuse de sa maladie.

#### EVOLUTION DE LA MALADIE

##### *Symptômes à l'arrivée de la malade:*

Asthénie marquée, toux et angine. Eruption scarlatiniforme, nausées, vomissements alimentaires. Température élevée, cet état fébrile se maintient à 104° et 105° dans les heures qui suivent son admission, parfois du délire et apparition d'épistaxis et de chéilites hémorragiques.

*A l'examen:* La fillette présente une otite moyenne bilatérale, un coryza purulent, une ulcération à la face interne des joues, une langue sèche, déshydratée, framboisiforme et desquamante, des amygdales hypertrophiées et purulentes, une adénite sous-maxillaire, un rash scarlatiniforme et plis.

Pouls: 148, Température 104°, T.A.

118/60.

Coeur: bruit régulier, claquement du deuxième bruit mitral, bruit assourdi.

Le lendemain, à la visite des médecins ceux-ci constatent que les antibiotiques ont bien agi, mais son état demeure toxique. Les signes d'endocardite persistent.

Au bout de quelques jours, le coryza diminue, le facies est moins intoxiqué, l'état général s'améliore beaucoup et une desquamation abondante apparaît.

Après dix jours d'hospitalisation, les signes généraux sont en régression et la desquamation suit son cours. Les bruits du coeur donnent assourdissement du 1<sup>er</sup> et claquement du 2<sup>e</sup> foyer mitral. La température baisse graduellement. On considère son état satisfaisant vers le 15<sup>e</sup> jour. La complication d'endomyocardite est stationnaire, mais la maladie est contrôlée.

Au départ, un souffle systolique très léger persiste mais en prévenant les parents de traiter l'enfant avec ménagements tout rentrera dans l'ordre et la petite pourra poursuivre son année scolaire.

#### SOINS HYGIÉNIQUES

S'agissant dans ce cas, d'une ma-

ladié *contagieuse*, la technique de *brossage* est rigoureusement observée. L'enfant dans son état fébrile fait de l'incontinence jour et nuit, ce qui nécessite une surveillance étroite du siège. En plus de la scarlatine, elle est atteinte d'impétigo au niveau des joues, endroits de prédilection pour le grattage. Il faut la corriger tôt pour éviter l'envahissement de la peau. La patience unie à un peu de fermeté met fin à cette mauvaise habitude. Les soins aseptiques d'usage et une propreté particulière évident à l'enfant d'autres complications. Sa santé récupérée, l'enfant retourne à ses parents après un mois d'hospitalisation.

Avant son départ, tenant compte que la patiente vit dans un milieu de contagion depuis son entrée à l'hôpital, une technique de départ s'impose. C'est ainsi qu'une *grande toilette*, très minutieuse permet à la fillette de reprendre contact avec l'extérieur sans danger de transporter des germes. Ses parents viennent la cueillir comme une rose

encore frêle, ils l'entourent d'une affection chaude et bienfaisante et ne taisent pas leur joie de retrouver leur fille unique avec une santé recouvrée. De son côté, l'enfant est un peu gauche à manifester sa joie, elle s'agrippe instinctivement au cou de son papa, quitte avec une grosse larme sur la joue, la "ma tante" infirmière qui pendant un long mois n'a cessé de veiller sur elle.

C'est ainsi que se ferme la page de la présente histoire. Ce 19 octobre marque le jour de départ de la petite Carole. Je la regarde s'éloigner avec des regrets car elle apporte avec elle un peu de moi-même. A la tristesse d'un moment fait place la satisfaction du devoir accompli et le témoignage d'avoir à l'instar des médecins contribué au rétablissement de ma jeune patiente. De plus, j'ai acquis une expérience nouvelle, un enseignement pratique et l'intime conviction que le nursing fécond est invariablement lié au cœur et à l'âme d'une infirmière.

## Sélection

### Commentaires

Le monde serait probablement encore dans l'âge des ténèbres si nous n'avions pas eu d'archives. L'histoire, la littérature, la musique, la médecine, le nursing, n'existeraient peut-être pas.

Les notes conservées par les premières religieuses hospitalières furent précieuses à Florence Nightingale pour établir la profession sur des bases plus solides. Ces premiers dossiers ainsi que les siens lui ont été utiles pour démontrer au monde que le nursing et la médecine devraient être unis afin de donner aux malades et aux blessés les soins dont ils avaient besoin.

Les rapports sont devenus une habitude dans la vie de l'infirmière professionnelle. Le progrès du patient est noté dans ses menus détails, et le médecin se sert du dossier comme moyen de diagnostic et de traitement. Par la suite ces dossiers servent pour la recherche médicale et ils aident à une connaissance plus précise des symptômes.

Il y a de nombreux exemples qui pourraient servir à faire valoir l'importance des dossiers. Cependant, il y a beaucoup d'endroits, spé-

cialement dans les petits centres, où ils sont souvent incomplets. Il n'y a pas une banque qui tenterait de manier l'argent des gens sans tenir un compte détaillé des moindres transactions. Combien plus important d'avoir des dossiers suffisants quand il s'agit de vies humaines. Ceux-ci sont essentiels pour les bons soins à donner aux patients.

Plusieurs infirmières se rappellent très bien les symptômes constatés chez tel ou tel patient et les signes d'amélioration de la maladie, mais elles sont troublées quand on leur demande des précisions. Les informations conservées dans la mémoire n'aident pas beaucoup le patient, le médecin et l'infirmière.

Il arrive aussi que certaines infirmières commettent l'erreur de passer trop de temps à faire des rapports, soit par la répétition de certains renseignements, ou en les recopiant d'une formule à une autre. Il ne faut pas non plus que la manière de faire vos rapports soit si compliquée, que vous soyez seule à les comprendre.

Il faut connaître le but principal des dossiers qui est de faciliter le soin de chaque patient. Le dossier contient généralement l'histoire de l'état de santé du patient dans



le passé et de sa maladie présente, le rapport de l'examen physique, les rapports du laboratoire, le rapport du médecin interne, les notes périodiques concernant l'amélioration de l'état du malade, la fiche de température, les ordonnances prescrites par le médecin et les notes des infirmières. Quand le patient quitte l'hôpital, le médecin traitant y ajoute au diagnostic provisoire au moins un diagnostic, ou plusieurs selon le cas.

En plus, le dossier aide la mémoire du médecin. Comme la pratique de la médecine est devenue plus technique et que l'on fait des examens et épreuves de toutes sortes, les rapports écrits sont devenus indispensables.

Le dossier sert aussi de moyen de communication entre les diverses personnes qui soignent le patient; le médecin, l'infirmière, l'assistante sociale, la physiothérapeute, etc.

Le dossier est un document important qui peut servir à prouver certains droits légaux et financiers du patient; par exemple, en cas de réclamations pour accidents, aux compagnies d'assurances, et afin d'attribuer une juste compensation aux travailleurs et aux vétérans. Il est important pour la protection du médecin et de l'hôpital en cas de poursuite judiciaire.

Finalement, le dossier a une grande valeur dans le domaine des recherches médicales.

A certaines d'entre-nous, la tenue des dossiers nous paraît une perte de temps, à d'autres une tâche ingrate et ennuyeuse, mais nous serons toutes mieux disposées à faire cet effort si nous avons en vue le bien-être du patient ainsi que l'avenir de la médecine et du nursing. — *Nursing Outlook*, Mars, 1956.

## K.P. for Double-Duty Homemakers

(Continued from page 884)

celery and olives are all you need. You can add a simple dessert such as lady fingers shrouded in lemon or chocolate sauce. These sauces can be kept on hand in covered jars in your refrigerator.

A salad plate meal might be made up of a fish or chicken salad garnished with small tomato jelly molds, or by tomato-wedges. Serve with hot rolls and peas in lettuce-cups, lightly covered with French dressing. Warm gingerbread or chocolate cake (package mix) with whipped cream would make a good topper-offer, and coffee is taken

for granted for any meal.

Be sure to give plenty of thought to the cake, muffin or roll mixes now so carefully and scientifically prepared. You can stir up and serve a real delicacy after you reach home and make no apologies either! Frozen foods that are entirely prepared are a joy to the married nurse who also has to do K. P. duty. They're good to have on hand for those emergencies that occur every so often. You'll find that if you make out lists, shop intelligently, and adhere to the system you set up, you'll manage very well and take care of both your jobs with efficiency.

Eating habits the world over are undergoing drastic change. Western Europe is consuming more fruit, milk and cheese than before the war. Bread is replacing rice in some countries of southeast Asia. Americans are eating less grain products and potatoes and more eggs, green vegetables, citrus

fruits and tomatoes. Economic factors play a role in such transitions. At low income levels, people eat mostly cereals, starchy roots and tubers. As their wealth increases they resort more to peas and beans, animal products, other vegetables and fruits.

— *Scope*

In the absence of some compelling complaint, the average man or woman infrequently seeks out his personal physician routinely and at stated intervals for a periodic health appraisal. For one reason or another, the public has not fully accepted

this positive approach to preventive medicine as applied to the individual and for which he must pay himself, even though the cost be moderate and reasonable.

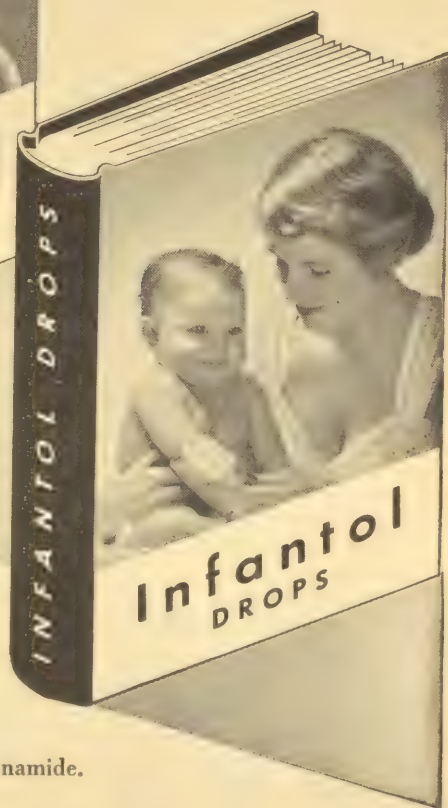
— *Medical Times*

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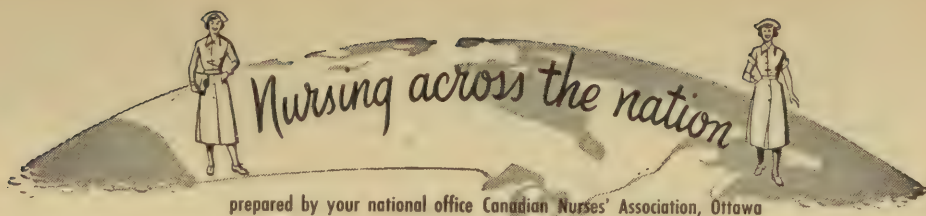


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F R A N K   W .   H O R N E R   L I M I T E D  
M O N T R E A L

C A N A D A



## Miracles — Yes or No?

Are the days of miracles over? One wouldn't think so if one could sit in on the Regional Directors' Conference, Victorian Order of Nurses for Canada. Twice a year the national staff of V.O.N. meet at their national headquarters in Ottawa. The other day in a discussion of rehabilitation and the part the V.O.N. is playing in rehabilitation programs, case histories were reviewed which sounded more like miracles than anything we've heard. Here is the gist of some of the cases discussed:

A man who had worked on a ferry boat for some years was stricken suddenly with a cerebral hemorrhage that paralyzed his right arm and leg. After he was transferred from hospital to his home, the V.O.N. visited daily on request of the family doctor. Following such an active life, his disability concerned him greatly. Gradually, under the guidance of the nurse and with practice and perseverance he was able to flex his leg but not extend it. The joy of accomplishment showed in his face when upon the arrival of the nurse he greeted her with "Look nurse, I can do it."

The next step was to be able to hold a cup to take a drink. This was accomplished by using an empty tin cup, so that if he did drop it there would not be a casualty. Then a little water was put in it, then a porcelain cup was used, and finally he was able to master a glass of water, or a cup of tea. This took weeks of patience, encouragement and every day practice. What person, who through days and weeks of being fed does not hail the day with real joy when he or she can feed herself?

\* \* \*

Mrs. X, a woman in her early forties, was confined in hospital. Within two weeks following her delivery she suffered a cerebral hemorrhage resulting in paralysis of her left arm and leg.

Following this she became very depressed as she felt that she would never be able to look after her new baby and other members of her family (two children and husband).

Her situation seemed so hopeless that she had no interest in carrying out the treatment and no desire to see if any improvement could be made in her condition. She was discharged home under the care of the physiotherapist and a housekeeper.

After a period of time the family found that they could not afford to carry on with the treatments. Within six months of the wife's illness the husband was diagnosed as an inoperable cancer patient and died within a short time.

It was then that the wife realized that it was very important for her to take more responsibility for her family. It was suggested that she seek help from the Victorian Order of Nurses.

The Victorian Order nurse visited daily and under the direction of the doctor gave the necessary treatments and exercises. The encouragement that the patient received from the nurses' visits was a great factor in her recovery. Over a period of time improvements were gradually noted.

Today, after three years, the patient is completely responsible without outside help for her own housework. Some assistance is given by her older sons. The Victorian Order of Nurses continue their visits on a spaced basis but these will soon be discontinued as the patient gains complete independence.

\* \* \*

With Canada's population age level increasing, with cardiovascular disease on the increase, and, to be completely mercenary, with the cost of illness increasing, what next to prevention itself could be more important than the part nurses can play in the rehabilitation of our patients? What must be the joy and sense of accomplishment of patients thus helped!



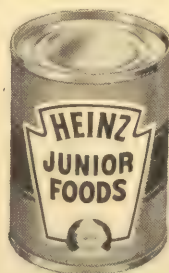
# Looks as if he belongs to a family of good cooks



Even the most conscientious young mother finds it difficult to cope with the techniques of modern baby feeding. She lacks time . . . facilities . . . and often access to the best quality foods. It is not always easy, or convenient for her to adhere to a well-balanced diet for the toddler who has graduated from strained food and is not yet ready for adult fare.

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BFM-556A

## HEINZ Junior Foods

## Ideas for Chapter Meetings

Could your National Office help with your chapter meetings? *The Canadian Nurse* has carried articles on accreditation of schools of nursing. Those who attended the biennial meeting in Winnipeg know that the voting delegates there reaffirmed belief in the principle of accreditation of schools of nursing and voted to conduct a pilot study of evaluation of schools of nursing as a possible preliminary to a full accrediting program.

We believe that the first step in any program is the education of ourselves. Accordingly, our thoughts go immediately to the chapter meeting. What better place to discuss this whole topic? In the chapter meeting each member of the C.N.A. can say what she personally thinks of accreditation; or it may be that this whole idea of accreditation of schools of nursing is new to us. Of course we have heard, and perhaps even spoken of accreditation, but what is really involved? What are the techniques of the accrediting program? What staff is required and what is the cost? These are questions we are all asking. So let's talk it over, in meetings, in discussion groups at our chapter meetings. To assist local groups in this endeavor National Office has prepared:

1. A speaker's brochure.
2. Sample questionnaires that might

be used at the chapter meeting. Try handing them out as the nurses gather. Ask them to fill them out before the meeting and again following the meeting.

3. Loan folder for those who really want to go "into the depths" of this subject.

If we in National Office can help in the organization of your chapter meetings let us know.

## Three Provinces Visited

The fortieth anniversary of the N.B. A.R.N. took place in October. The annual meeting of the Association highlighted nursing education as a result of the research project carried out during the past year in that province. A panel discussion on this topic was presented in which the CNA Nursing Education secretary participated.

In October the R.N.A.O. held a conference on "Improving the Quality of Nursing Care" at Sunnybrook Hospital, Toronto. In the planning period, questionnaires were sent to 1164 agencies and the topic of the conference was chosen from the replies. Our Nursing Service secretary attended as a resource person.

A visit to Newfoundland was recently made by the General Secretary, where she visited St. John's and addressed nurses gathered for the Public Health Convention in that city.

## Annual Meeting in Saskatchewan

**T**WO HUNDRED AND TWENTY-SEVEN members attended the sessions of the 39th convention, S.R.N.A., held in Regina in May. Miss Mary T. Mackenzie, president, chaired all main sessions. Mayor L. H. Hammond and Rev. J. R. Hord participated in the opening ceremony which was televised for the benefit of members unable to attend. Miss V. Antonini expressed the appreciation of the members to the honored guests.

The program for this annual meeting had been planned to provide as much information as possible regarding developments in nursing in Canada and particularly in Saskatchewan. A survey of topics covered serves to indicate

that this objective was most adequately attained. "Recent Developments in Saskatchewan's Health Services Program" were comprehensively discussed by Dr. Milton I. Roemer, Director, Medical Hospital Services Branch of the Department of Public Health. A panel chaired by Miss L. Miner, "What is New in Nursing and Emergency Planning?" brought nurses up-to-date in areas where their participation is of immediate concern. As part of this topic Mr. C. P. Johnston, provincial director of Civil Defence, discussed "Developments in Civil Defence Health Services Planning"; Miss Hazel Keeler described the National League for Nursing Test



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Pool Examinations and their use in the province; Miss Mary Mackenzie presented current developments in Canadian nursing and Miss Lola Wilson reported on developments in the centralized teaching program and the work of the Kellogg Foundation. Further stimulus was supplied in the addresses given by Miss M. Pearl Stiver, General Secretary, and Miss Leonora Collatz, Executive-Secretary of the Minnesota Board of Nursing and assistant to the Division of Nursing Education of the National League for Nursing. "National Accreditation — a Forward Step in Nursing" was the timely subject of the address by Miss Collatz.

Mrs. June Orr chaired the student session when the guest speaker was Dr. H. O. Dillenberg, medical bacteriologist of the Provincial laboratory. Dr. Dillenberg spoke on "Bacterial Cross-Infections in Medical Institutions and Their Prevention."

Highlights of the work undertaken and accomplished by the provincial association included the establishment of a pension plan for provincial office staff; the development of the new "Recommendations Relating to Personnel Policies for Nurses"; activities in relation to tuberculosis and psychiatric affiliations for nursing students, financial aid for

students, bursaries for graduate study; civil defence as it related to nursing. A new fee schedule for private nurses was accepted by the general session. At their special meeting, the public health nurses welcomed Dr. A. C. Kanaar, Medical Director, Physical Restoration Division as the guest speaker. His subject was "The Nurse's Role in Rehabilitation." "The Rh Factor and Hemolytic Diseases of the Newborn" were reviewed by Dr. O. E. Laxdal in his address during the Institutional Nursing session.

Reports were presented from the various provincial committees telling the story of a busy year. The treasurer's report indicated a satisfactory financial picture for the new executive. Members elected to office included: Mary T. Mackenzie, pres.; L. Willis, L. McColl, vice-pres.; Committees: E. James, nursing education; V. Antonini, nursing service; Mrs. C. O'Shaughnessy, publicity; L. Long, chapters. In 1957, the annual meeting will be held in Saskatoon, May 16-17.

LOLA WILSON  
Executive-Secretary  
Treasurer  
Saskatchewan Registered  
Nurses' Association

## *Le Nursing à travers le pays*

### *Quelques suggestions concernant les assemblées de districts.*

Votre secrétariat national peut-il vous aider dans vos assemblées de districts ou de chapitres? Le revue *L'Infirmière Canadienne* a publié des articles sur l'accréditation des écoles d'infirmières. Celles d'entre vous qui ont assisté au congrès de Winnipeg savent que les déléguées se sont prononcées une fois de plus en faveur du principe de l'accréditation des écoles d'infirmières et d'une étude sur l'évaluation des écoles en vue de préparer le programme d'accréditation. Nous estimons que le premier pas à faire dans l'organisation de tout programme est de nous renseigner nous-mêmes. Notre pensée s'est donc immédiatement reportée au district et à ses réunions; y a-t-il une meilleure occasion pour discuter de cette question? Dans les assemblées de districts, chaque membre peut dire ce qu'il pense de l'accréditation; il se peut bien que la question ne nous soit pas encore très familière. Bien sûr, nous avons entendu parler de l'accréditation et même

nous en avons un peu discuté mais, en réalité, de quoi s'agit-il réellement? Quelles sont les techniques d'un programme d'accréditation? Quel personnel cela requiert-il? Quel en est le coût? Voilà autant de questions que nous nous posons. Alors, parlons-en dans nos assemblées, discutons de ce sujet en groupe. Afin d'aider les associations locales, le secrétariat national a préparé:

- 1) Une brochure à l'usage du conférencier.
- 2) Des questionnaires pouvant servir dans les assemblées et que l'on distribuera aux infirmières lors de ces réunions. Demandez-leur d'y répondre avant l'assemblée et de nouveau après l'assemblée.

- 3) Un dossier contenant une certaine documentation pouvant être prêté à celles qui désirent étudier la question plus à fond.

Si nous pouvons vous être utiles dans l'organisation de vos assemblées, faites-le nous savoir.

### *Miracles, oui ou non?*

Le temps des miracles est-il passé? On



## “Meat protein as well retained as milk protein...”

**E**VEN premature infants digested, utilized and retained the proteins and fat in specially prepared Meats for Babies according to Sisson, Emmel & Filer, “Meat in the Diet of Prematures”, Pediatrics, 7, 89 (1951).

The authors state, in part: “Meat protein is as well retained and utilized as milk protein by the premature infant and is therefore as safe and efficient a source of protein as milk. The fat absorption of the premature infant is not significantly altered when the milk in the diet is partly or wholly replaced by meat fat or meat fat and olive oil.”

*Swift's Meats for Babies was the original product of this kind placed on the market. Prepared from only fine, lean meat, the food is*

*cooked and milled to a fine purée. The texture is soft, moist and easily fed in formula or for initial spoon feeding just as it comes from the can. There are seven kinds for variety and special conditions: Beef, Lamb, Pork, Veal, Liver, Heart, Liver and Bacon, and also Swift's Egg Yolks for Babies, Salmon Seafood for Babies and the chopped Swift's Meats for Juniors.*

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ne le croirait pas en écoutant les délibérations des membres du Victorian Order of Nurses sur la réhabilitation. Deux fois par année, ce groupe se réunit; cette année l'on étudia le rôle du V.O.N. dans la réhabilitation; les histoires de cas présentées furent étonnantes et les résultats obtenus semblaient tenir du miracle. En voici quelques exemples.

"Un homme travaillant dans un bateau passeur depuis plusieurs années fut soudain atteint d'hémorragie cérébrale; il resta paralysé du bras et de la jambe gauche. Une fois sorti de l'hôpital, il fut visité tous les jours par une infirmière du V.O.N., à la demande du médecin. Il va sans dire qu'après avoir mené une vie aussi active, son infirmité actuelle l'inquiétait grandement. Graduellement, sous la direction de l'infirmière, avec de la pratique et de la persévérance il devint capable de plier sa jambe mais non de l'étendre; mais un jour, la joie rayonnait sur son visage lorsqu'il vit entrer l'infirmière: "Regardez, dit-il, je puis le faire."

Il s'agissait ensuite de lui faire tenir une tasse et de boire. L'exercice débuta avec une tasse de fer-blanc et vide; le malade pouvait donc l'échapper sans crainte de rien gâcher; puis on y mit un peu d'eau ensuite on se servit d'une tasse de porcelaine et enfin, il vint à pouvoir tenir et boire une tasse de thé ou un verre d'eau sans aucun accident. Cela demanda naturellement des semaines de patience, d'encouragement et des exercices quotidiens. Quelle personne qui après avoir été alimentée comme un bébé durant des jours, des semaines, ne salue pas avec la plus grande joie le jour où elle peut manger seule!

Voici un autre cas remarquable: Madame X, au début de la quarantaine, accoucha à l'hôpital. Deux semaines après elle fut atteinte d'hémorragie cérébrale suivie de paralysie du bras et de la jambe gauche; elle devint très déprimée et crut qu'elle ne pourrait jamais plus prendre soin de sa famille (2 enfants et le père).

Son état semblait désespéré; elle ne témoignait aucun intérêt au traitement ni aucun désir d'améliorer son état; à son départ de l'hôpital pour la maison, elle fut confiée aux soins d'une physiothérapeute et d'une ménagère. Après quelque temps, la famille, faute de ressources, dû cesser les traitements. Six mois après la maladie de son épouse, le mari tomba malade d'un cancer jugé inopérable et mourut peu de temps après.

C'est alors que Madame X. réalisa qu'elle était obligée de prendre la responsabilité de sa famille et quelqu'un lui suggéra de de-

mander le secours du Victorian Order of Nurses.

L'infirmière du V.O.N. la visita quotidiennement et, sous la direction du médecin, lui administra les traitements et lui fit faire les exercices prescrits. L'encouragement que lui apporta l'infirmière fut un facteur important de sa guérison.

Aujourd'hui, après trois ans, Madame X fait tout le travail de la maison avec l'aide de son fils aîné. L'infirmière du V.O.N. la visite encore de temps à autre mais bientôt cela ne sera plus nécessaire.

L'augmentation de la durée moyenne de la vie, l'accroissement des maladies cardiovasculaires et, si l'on veut être tout à fait matérialiste, avec le coût de la maladie qui augmente sans cesse, qu'y a-t-il de plus important, après la prévention, que la réhabilitation de nos malades? Quelle ne doit pas être la joie de ces personnes que l'on a ainsi secourues!

### *Visites dans trois provinces*

L'Association des Infirmières du Nouveau-Brunswick célébrait en octobre dernier son quarantième anniversaire. A l'assemblée annuelle, le sujet du programme fut: "L'éducation en Nursing" une étude ayant été faite sur cette question au cours de l'année.

En octobre, l'Association des Infirmières d'Ontario tient une conférence sur "L'Amélioration de la qualité des soins infirmiers", à l'Hôpital Sunnybrook de Toronto. Le sujet fut choisi d'après les réponses reçues à la suite de l'envoi de 1164 questionnaires.

Une visite fut faite dernièrement à Terre-neuve par la secrétaire générale de l'A.I.C. qui visita St-Jean et adressa la parole aux infirmières réunies dans cette ville.

### *Chez les nôtres*

L'éducation du personnel tient actuellement la vedette dans nos institutions. A l'Hôpital Maisonneuve, avant l'entrée des élèves, les infirmières furent invitées à participer à des journées d'études. L'orientation, les relations interpersonnelles, le travail d'équipe, l'interrelation de l'école et du service du nursing, méthodes d'enseignement, furent les sujets au programme.

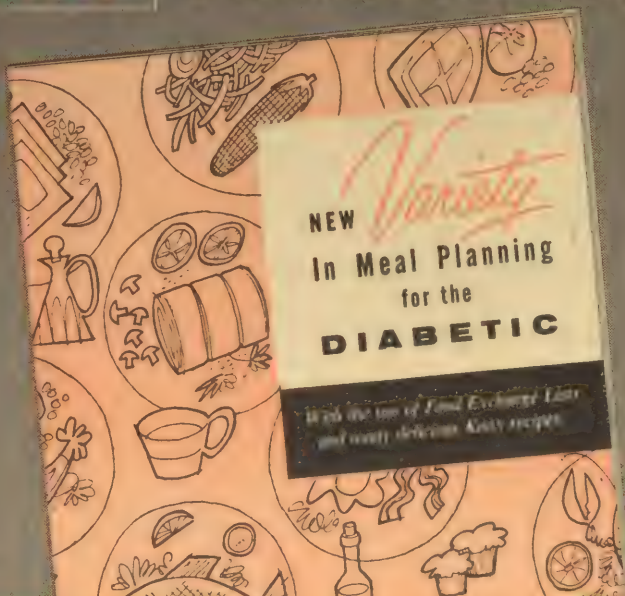
A l'Université de Montréal, l'Ecole d'Hygiène offre aux infirmières des unités sanitaires un programme intéressant et pratique.

L'Association des Infirmières réunit en congrès les infirmières du service industriel. L'hygiène mentale dans l'industrie fera l'objet d'une étude spéciale.



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1. The Food Exchange Lists referred to are based on material in "Meal Planning with Exchange Lists" prepared by Committees of American Diabetes Association, Inc., and The American Dietetic Association in cooperation with the Chronic Disease Program, Public Health Service, Department of Health, Education and Welfare.

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# The Meaning of Rehabilitation

FRANK G. WELLARD

**R**EHABILITATION HAS BECOME a word to conjure with. Not that it hasn't a right to be used in the many applications in which it is — because there is authority for them — but because it wasn't commonly used in those applications until it came to be widely used with reference to disabled persons.

Here are the definitions that Webster lists, first for "rehabilitate," then for "rehabilitation":

*Rehabilitate:*

1. To invest or clothe again with some right, authority or dignity; to restore to a former capacity; to reinstate; to qualify again; to restore, as a delinquent, to a former right, rank or privilege lost or forfeited; a term primarily of civil and canon law.

2. To restore to good repute by vindicating; to clear of unjust or unfounded charges; to re-establish the good name of.

3. To restore to a former state of solvency, efficiency or the like.

4. To put on a proper basis or into a previous good state again; to restore; to re-establish; specifically, to restore a person, as a disabled soldier, to a status of independent earning power through a course of instruction under state supervision, especially along vocational lines.

*Rehabilitation:* — The act, process, or result of rehabilitating; the state of being rehabilitated; restoration of a right, one's good name, one's health and efficiency, etc.

Sir Ernest Gower, English author of "The Complete Plain Words," quotes one, Ivor Brown, as saying this about the uses and abuses of the word "rehabilitation":

The present darling of the departments . . . is rehabilitation, a word originally applied to the restoration of a degraded man's rank and privileges. By the middle of the 19th century, it was occasionally used to mean restoration of other kinds. Suddenly it has become the administrator's pet. A year or two ago, nothing was mended, renewed or restored. Everything had to be reconditioned. Now re-

conditioning has been supplemented by rehabilitation, which has the merit of being one syllable longer. The blessed word "goes" officially with everything from houses to invalids . . .

The word leaps at us from all sides. There is the Civilian Rehabilitation Branch in the Department of Labor. There is the Maritime Marshlands Rehabilitation Act. There is the Prairie Farm Rehabilitation Act. Closer home, there is a strong move to rehabilitate the ailing coal mining industry; and when the wind blows too hard in the fall, the apple industry needs rehabilitating. Last year, shortly before the era of ferry transportation to Cape Breton closed forever, one of the ferries burned in its dock. The press carried the report next day that it would be refloated and moved to a neighboring marine slip for rehabilitation. And a special fund was created to "rehabilitate the devastated homes" in the Liverpool area after the forest fires last year.

It would be nice, from our point of view, if the word "rehabilitation" could be used just to define what we are interested in — certain services for disabled people.

What, then, should we accept as our definition of rehabilitation? The most used one is that of the International Labor Organization — "the restoration of the disabled to the fullest physical, mental, social, vocational and economic usefulness of which they are capable." Going back to Webster for a moment, our concept is broadened as we accept — "the act, process, or result of rehabilitating" all as rehabilitation. It is not only a process; it is any or all of the elements in that process, and it is the end result of the process.

To go a bit further, there are a number of quotable quotes which help to clarify our thinking about rehabilitation. Most references are to the physically handicapped. We skirt the subject of rehabilitation of the mentally ill, because, although we are aware of the magnitude of the problem, we are less aware of what we can do about it. We consider the mental problems of the physically handicapped, and look for-

---

Mr. Wellard is Rehabilitation Coordinator for the province of Nova Scotia.

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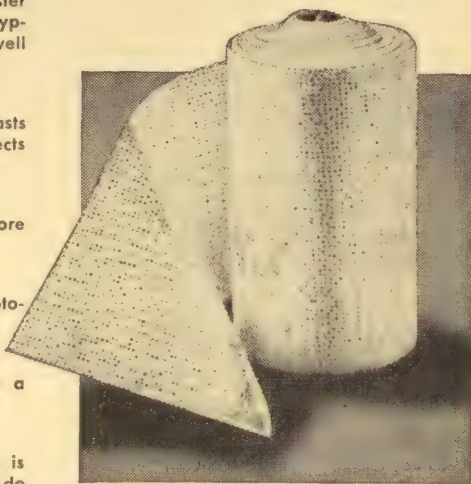
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ward to the time when it will be possible to do as much for the mentally ill. It is to be noted, too, that while this paper refers particularly to the physically disabled, all of the principles cited apply with only slight reservation to the conditions of the aged or the chronically ill.

The physically handicapped, then, are those individuals who have a physical defect, obvious or hidden, which limits their capacity to work or evokes an unfavorable social attitude. That bears closer examination. We are inclined to think first of the paraplegic or the amputee, or the person ambulant with braces and canes or crutches when we think of the disabled. But what of the cardiac, the tuberculous, the diabetic, to name only a few who may be even more disabled than the more obvious are, and are more handicapped because their disabilities are hidden and therefore do not evoke for them a sympathetic and understanding consideration of their condition? And what of the people whose disabilities do not prevent them from working, but do incite fear or repugnance in those with whom they are to work and live? The ex-tuberculous still often face this handicap. We know the annoyance and frustration with which we, whole people, often face association with the deaf mute or with the drooling and grimacing cerebral palsied. There are other examples of disabilities which evoke an unfavorable social attitude.

For these and the many other kinds of disabled persons, rehabilitation has come to be regarded as "the process, the creative process, in which the remaining physical and mental capacities of the physically handicapped are utilized and developed to their highest efficiency." It is an organized and systematic method by which the physical, mental and vocational powers of the individual are improved to the point where he can compete with equal opportunity with the so-called non-handicapped.

"The so-called non-handicapped" is well said. If proper recognition is given to areas of competence which exist or may be developed, handicaps become less significant. After all, what is important is not what people cannot do because of their disabilities, but what they can do in spite of their disabilities.

Today society, business and industry pay for ability to think and for hand skill. Most disabled people can do some useful and gainful work. You don't have to be able to run 100 yards in so many seconds to be a great leader. The average individual uses only one-third of this physical ability in doing a day's work.

We come, then, to a consideration of the various elements that make up rehabilitation. Broadly speaking there are three. They are: *medical rehabilitation*, *vocational rehabilitation*, and *job placement*. Involved in these basic elements are many special skills. The areas in which these skills operate will overlap in many places. Therefore it is most important that each specialist recognize the areas in which he or she can and should serve. At the same time, each specialist should have some knowledge of and appreciation of the role of all the other specialists. Out of this approach comes the concept of the team.

Because disability is involved, the whole rehabilitation plan for an individual revolves around his medical condition. The doctor is the key person on the team. Medical attention is necessary as soon as possible after the disability is incurred or recognized, so that the greatest degree of physical restoration is possible. When this has been achieved, medical supervision of any further rehabilitation process is needed to ensure that there is no aggravation or recurrence of the disabling condition.

The doctor has certain allies as he goes about the business of getting his patient back to as nearly normal as possible. These allies are the nurse, the physiotherapist, the occupational therapist, the speech therapist, the remedial gymnast, the prosthetist. All may not be needed for each case; but all are there, ready to bring their skills to bear when needed.

Ready to interpret the effects of disability to patient and family, if necessary, is the social worker with special skill in handling emotional problems and personal adjustments.

The purpose in restoring the disabled person to the best possible physical condition is twofold. It is to make him as comfortable as possible, and it is to make him as fit as possible to

## INTRAMUSCULAR

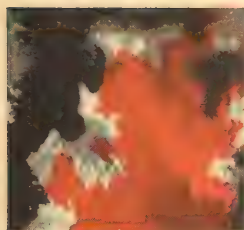
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Recent investigation has extended the list of indications for Intramuscular VARIDASE therapy to include abscesses, burns, cellulitis, edema, epididymitis, hemarthrosis, sinusitis, lymphangitis, lymphadenitis, and thrombophlebitis with or without superimposed infection.

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*Administration:* INTRAMUSCULAR, deep in the upper, outer quadrant of the buttock



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earn a living and be independent. If it happens to be a housewife who is concerned, it is to make her as fit as possible to carry on her domestic duties. If you don't think that is earning a living, just ask a housewife!

In principle, it is better to rehabilitate a disabled person to the occupation they originally had, if they had one. It has to be recognized, though, that in many cases of severe disability this is not possible. There is comparatively little vocational adjustment involved for the bookkeeper who has recovered from far-advanced tuberculosis or through an accident, is obliged to get about with the help of crutches. If the same person were a seaman or a line-man for a power company, however, a complete change of vocation is necessary. Here new skills come into play. The psychologist or the vocational counsellor helps the disabled to find the interest or skill which they can develop to the greatest advantage. This is not a hit and miss proposition. Standardized tests establish the rehabilitant's intelligence level, and point to the field in which an occupation may be selected. The final selection is made in consultation with the doctor and the employment specialist. There is no point in picking a type of work that is going to be physically harmful. There is little point in selecting a vocation at which a person cannot get a job.

At this point it is quite possible that some preparation for a new vocation will be necessary. A person with a disability can well be benefited by training for a job that will eliminate the handicap imposed by his disability. If he has the educational background and the intelligence to master a new trade, training awaits him either in a school or on the job at which he will work when he becomes skilled. What new horizons have been brought into the view of handicapped people who, only a few years ago were condemned to a life of comparative uselessness! There is literally no limit to the skill that a disabled person may acquire if they have the basic qualifications to start them on a career of usefulness.

Not everybody who becomes disabled is a good training prospect. It is folly to think that everybody who is injured should be made over into a new being who does something entirely different

from what he did before. Age, intelligence, education are all factors which determine whether a person having attained their physical optimum, should be placed on the labor market or should be trained. The greatest problems are found with the people who need a skilled job, but have not the mentality nor the education to benefit from training. This is particularly so in provinces where the economy is based on primary industries — fishing, farming, lumbering and mining. A great many people who become disabled in their forties or later, are found to have left school when they were in Grade III or IV. They have worked hard all their lives, and there have been no complications until something happened that prevents them from working hard again. If they cannot be trained, or cannot benefit from training, every effort must be made to find a job into which they can fit with their residual capabilities.

Job placement of the physically handicapped is a special skill in itself. It involves not only matching the physical and mental qualifications of the disabled person who wants employment with the job he can do. The placement specialist must be prepared to go out to look in industry and in the labor market for jobs for his clients. And he must know how to sell his product, because it does have to be sold. Employers do not yet accept the fact that a person with a disability is not necessarily handicapped. There are too many who automatically say, "Sorry we have nothing for you today," meaning that they have nothing for a disabled applicant ever. They say it without giving any thought to the fact that before them is a person who can do some things, the things they are asking for a chance to do, just as well as somebody who has a whole body, but has not the special need and the drive to justify the fact that he is a good bet for the job.

Employment is the end product of rehabilitation, if you like. The man who has become disabled needs more than to be put back together again if he has a family dependent on him. He needs more than to be trained for an occupation. All the work of doctors, nurses, therapists, counsellors, results only in his being more comfortable in his body, but less comfortable in his mind if he cannot put his abilities to work.



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.....

The person who is handling the placement probably has the hardest part of the whole process of rehabilitation to accomplish. This is true because if that person fails in his part of rehabilitation, all the work, the skills and devotion that have been brought to bear by the other members of the team appear to have been for naught.

Since employment is so important, let us examine some of the possibilities more closely. One thing we do have to realize is that, in spite of the best that can be done for some cases medically and vocationally, they are never going to be able to go out and compete in the regular labor field. In some cases they will never again be able to leave their homes. In others they will never be able to work fast enough and steadily enough to be acceptable in a job situation where their rate of production may affect the effectiveness of a whole operation. On the other hand, if a work situation can be created for them, these people can do a lot to help to maintain themselves and can be more satisfied and self-respecting citizens as a result.

A work situation can be created for these people either in sheltered shops or in the home. Homebound and sheltered employment make useful producers of many who cannot compete in speed or cannot get out of their homes. In most cases they develop a business in collecting, repairing and reselling articles of used clothing and household fixtures and furniture. The repairing and reconditioning is done in what is known as a sheltered workshop where work and not speed is the essential.

Many disabled persons are job conditioned in this sort of an environment before moving into the regular labor stream again. Others find employment for the rest of their working days in a place where they are important because they can do *something*, and not because they can do it at such and such a speed. Usually a homebound employment program is associated with a sheltered workshop. Routine jobs of sewing, repairing or assembly or packaging can be done by the people who cannot get away from their homes, provided there is an organization for getting the work

to them and collecting it again.

I may have dwelt at some length on employment's part in rehabilitation. You will recognize, I am sure, the important place it has in the whole process. You will realize that modifications of the employment services for the disabled may be adaptable to the circumstances of the chronically ill, who form a very important part of the disabled.

We have talked about the team approach to rehabilitation and have listed members of the team. But so far we

have not mentioned, specifically, the most important member of the team. That is the disabled person who wants to be rehabilitated. He or she is the one who determines whether rehabilitation is going to be successful. Only the disabled can provide the motivation, the courage, the persistence in spite of obstacles. We can provide the services that restore, that train or retrain, but we cannot make the disabled use them. The disabled are not rehabilitated. They rehabilitate themselves.

## In Memoriam

**Cécile Clermont**, infirmière diplômée de l'Hôpital St.-Luc en mai 1933, est décédée subitement le 10 septembre dernier à l'âge de 47 ans. Mlle Clermont a fait longtemps du service privé puis a été présidente du Registre de l'Hôpital St-Luc durant de nombreuses années. En 1953, elle entrait au Laboratoire Provincial comme technicienne en chimie.

\* \* \*

**Eileen Eaves**, who graduated from the Royal Victoria Hospital, Montreal, in 1939 died on June 21, 1956 in Montreal.

\* \* \*

**Audrey Elliott**, who graduated from the Winnipeg General Hospital in 1953 died on September 2, 1956, following a brief

illness, at the age of 24. Miss Elliott was on the staff of Moose Jaw Union Hospital.

\* \* \*

**Alice Erskine**, who graduated from the Royal Victoria Hospital, Montreal, in 1899 died on July 28, 1956.

\* \* \*

**Ruth (Kool) Gaasenbeek** died recently at Kingston, Ont. After having received part of her training in Holland, Mrs. Gaasenbeek entered the school of nursing of the Greater Niagara Hospital, Niagara Falls, and graduated in 1955.

\* \* \*

**Margaret Hughes**, who graduated from The Mack Training School, General Hospital, St. Catharines, Ont., in 1896 died on August 10, 1956, in Portland, Oregon. The founder of the alumnae association of her school in 1901, Miss Hughes maintained close contact with it following her retirement from the public health field in which she spent most of her professional life.

\* \* \*

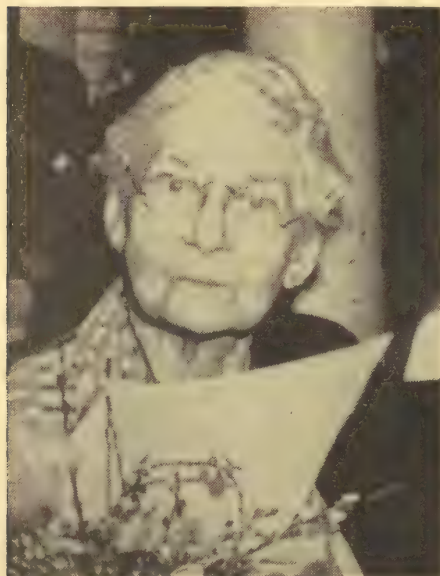
**Sandra Marie Long**, who graduated from Holy Cross Hospital, Calgary in 1956 was killed in a highway accident near Ponoka, Alta.

\* \* \*

**Laura B. (MacDermid) Lough**, who graduated from Lady Stanley Institute, Ottawa, in 1914 died on July 27, 1956. Mrs. Lough served overseas during World War 1.

\* \* \*

**Kathleen (Grattan) McLaughlin**, a graduate of the General Hospital, Saint John, N.B. died at Montreal on August 15, 1956, following a long illness. Mrs. McLaughlin had worked on the staff of the Moncton Hospital, St. Mary's Hospital,



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\* \* \*

**Mary Joyce Roberts**, who graduated from the Victoria Hospital, Prince Albert, died suddenly on September 8, 1956 in Trail B.C. Miss Roberts had worked on the staff of Mission Memorial Hospital, Mission City, St. Paul's Hospital, Vancouver, the Vancouver General Hospital, Chilliwack General Hospital and Trail-Tadanac Hospital.

\* \* \*

**Mary Francis Stevens**, who graduated from The Mack Training School, St. Catharines General Hospital in 1921, died on

August 2, 1956. Miss Stevens had engaged in private nursing.

\* \* \*

**Hilda Muir Stuart**, who graduated from Victoria Hospital, London, Ont. died on September 11, 1956. Miss Stuart served with the British Red Cross in Cairo and France during World War I. She received the Mons Medal, General Service and Victory Medals and the King George V Jubilee Medal. On her return to London she rejoined the staff of Victoria Hospital and became the principal of the school of nursing in 1931. She retired from her profession in 1948.

Authorities at the Oswestry hospital in England have discovered a new medicine for their women patients that works wonders and does not cost a cent — gossip panels to relay to them neighborhood goings-on. Volunteer "gossipers" move through the women's wards, spending 10 to 15 minutes to give each patient the latest birth, death and marriage news. Hospital officials say it does the patients "worlds of good."

The Delphic oracle said that I was the wisest of all the Greeks. It is because that I alone, of all the Greeks, know that I know nothing.

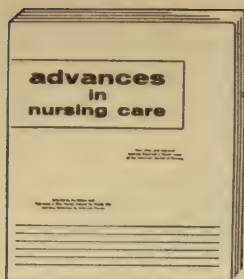
— SOCRATES

\* \* \*

The first condition I would give for happiness is to have a sense of values wider than one's own life and personality.

— SIR HUGH WALPOLE





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## Book Reviews

**From Custodial to Therapeutic Patient Care in Mental Hospitals**, by Milton Greenblatt, M.D., Richard Y. York, Ph.D. and Esther Lucile Brown, Ph.D. 484 pages. Russell Sage Foundation, New York. 1955. Price \$5.00.

*Reviewed by Miss M. Pike, Allan Memorial Institute, Royal Victoria Hospital, Montreal.*

In the introduction to this text we find what the authors consider to be the functions of a psychiatric hospital. They are divided and elaborated into the following working hypotheses. That function is:

The utilization of every form of treatment available for restoring patients to health or helping them improve sufficiently to be able to leave the hospital at the earliest possible moment; and, short of such success, it is aiding them to live as nearly normal lives as possible within the institutional setting.

The utilization of *every* form of therapy available requires planned systematic use of

the whole environment, consisting both of physical resources and social interaction between all categories of staff and patients.

For purposes of making effective therapeutic use of the social environment of the hospital, including improvement in the motivation of personnel, concepts and methods of research developed by the behavior sciences should be tested and utilized wherever feasible.

The origin, nature and results of the "Russell Sage Project" are next described.

Following this enlightening introduction the book is divided into three distinct parts. Each section reviews the unpleasant background of the past. Gradually we sense the tremendous strides in total environmental change evolving from the combined efforts of everyone: doctors, nurses, attendants, occupational therapists and the patients themselves. In conclusion the authors point hopefully, and possibly wistfully, into a future which embodies the best of all we can offer the mentally ill.



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These achievements were not easily made. The doubts, discussions, worries and fears are effectively illustrated by extracts from notes or quotations. The book ends on an encouraging note, but with a realistic long-term view of the many problems still confronting us. The extensive bibliography is valuable. This book is one that should have a place in every nursing school library.

**Thresholds, to Professional Nursing Practice**, by Frances M. McKenna, R.N., M.A. 347 pages. W. B. Saunders Company, Philadelphia. 1955. Price \$4.25.  
*Reviewed by Miss Gertrude M. Hall, Director of Nursing, Calgary General Hospital, Calgary.*

"As indicated by its title, this book is designed primarily to bridge the span of time which extends from an undetermined moment in a student's senior year until she has established herself as an independent professional worker." This, in the words of the author, is the purpose of the course in Professional Adjustments II.

The content and plan of the book represents years of teaching this particular course. Student reaction and comment is noted. The intent has been to place nursing in perspective with other vocations and to incorporate

ideals for service and performance.

Unit I contains an excellent chapter on "Thresholds to Adult Living." It appears to be a continuation of the foundations laid in the course given in the first year as Professional Adjustments.

Unit II deals with general considerations leading to employment — seeking, holding and leaving a position.

Unit III discusses opportunities for service in relation to hospitals, schools of nursing, occupational health and various other specialized areas.

Units IV & V are concerned with personal and professional obligations, with the exception of a brief reference to the I.C.N. The professional nursing organizations explained in great detail are those of the United States. Canadian students are quite at a loss to obtain similar information concerning the Canadian counterpart, the Canadian Nurses' Association. One cannot, of course, place the responsibility for this lack on the author or publisher. It is the business of Canadians to prepare their own material for courses in professional adjustments. The book is an excellent reference for teachers and senior students.

**Nutrition and Diet Therapy**, by Fairfax



T. Proudfit and Corinne H. Robinson. 826 pages. The Macmillan Company of Canada Ltd., 70 Bond Street, Toronto 2, Ontario. 11th Ed. 1955. Price \$5.25.

*Reviewed by Mrs. Marian Ross, Nutritionist, Department of Health, Parliament Buildings, Toronto, Ont.*

This text is designed for the nursing student. The book is divided into five sections covering nutrition in the normal diet and in the therapeutic diet.

Section I, "Normal Nutrition," discusses the relation of food to health, food requirements and normal metabolism of various food constituents. The United States "Recommended Daily Dietary Allowances" and the "Basic Seven" food grouping are given. For Canadian use, it would be necessary to substitute the "Canadian Dietary Standard" and the recommendations of "Canada's Food Rules." There is a practical chapter on meal planning for moderate and low cost meals and an interesting chapter on food patterns of various cultural groups.

Section II, "Normal Nutrition in Special Conditions," deals with dietary planning for pregnancy and lactation, the infant, the pre-school and school child and the older person.

Section III, "Diet Therapy," places emphasis on the use of the normal diet as the basis for planning the therapeutic diet. There is a new chapter on nutrition in children's diseases.

Section IV, "Practical Applications of Nutrition," concerns nutritive values, selection, care and preparation of food. A section of recipes follows with many recipes written for individual portions. These are suggested for use in the class laboratory.

The appendix of this text includes a range of tables of food values, average weight for height tables, a health score card, and extensive bibliography and additional references. This well-organized text achieves its stated purposes — to give the reader an appreciation of the role of nutrition in health; to present the fundamental principles of normal and therapeutic nutrition; to encourage the application of these principles to individuals of all age categories.

## Errors in Spelling

Everyone has doubts about the spelling of a word and the punctilious have immediate recourse to the dictionary. But there are errors of spelling of which the perpetrators are unconscious and in which they persist, to be thereby condemned. Could it be that nurses are guilty of any such in their correspondence?

After collecting and analyzing 30,000 misspellings by the college students, Dean Thomas C. Pollock of New York University has concluded that comparatively few words are responsible for a large percentage of spelling errors. The Dean enlisted the aid of 599 teachers of English in 52 colleges and universities. He wanted to find the words that college students actually misspell most often in their writing.

The university now has a list of words that give students the most frequent difficulty. The most frequently misspelled word or word-group was "their — they're — there" (440 times). In second and third places were "to—too—two" (434 times) and "receive" (357 times). The other words in the list of the first ten that cause the greatest trouble are (4) exist—existence—existent, (5) occur—occurred—occurring—occurrence, (6) definite—definitely—definition, (7) separate—separation, (8) believe—belief, (9) occasion and (10) lose—losing.

\* \* \*

Why is it that people who are troubled with insomnia are generally so proud of it?



## British Columbia

The following is a list of the staff changes which have occurred in the Division of Public Health Nursing, Department of health and Welfare:

**Appointments** — *Frances Nelson* (Vancouver Gen. Hosp., U.B.C.) to Prince George. *Lucille Leger* (St. Boniface Hosp.) to Cloverdale. *Lois Keating-Fisher* (Saskatoon City Hosp., McGill Univ.) to Courtenay. *Eva Wolf* (Calgary Gen. Hosp., U.B.C.) to Ladysmith. *Ruth Miller* (V.G.H., U.B.C.) to Courtenay. *Frances McAddoo* (Royal Columbian Hosp.) to Terrace. *Nora Larson* (Regina Gen. Hosp.) to Saanich and So. Vancouver Is. H.U. *Mrs. Lydia Boss* (V. G.H., U.B.C.) to Armstrong. *Dorothy Deeble* (St. Paul's Hosp., Vancouver, U.B.C.) to Kamloops. *Mrs. Jessie Bridges* (Univ. Hosp., Edmonton, U.B.C.) to Saanich and So. Vancouver Is. H.U. *Elaine Miller* (Royal Inland Hosp., Kamloops) to Coquitlam. *Nancy Idiens* (Royal Jubilee Hosp., Victoria) to Dawson Creek. *Joan Sutherland* (Toronto East Gen. Hosp., Univ. of Toronto) to Trail. *Mary McCulloch* (Toronto Gen. Hosp., U. of T.) to Abbotsford. *Mrs. Pamela (Dobbin) Weseen* (V.G.H., U.B.C.) to Mission. *Kathleen McAreavey* (City Hosp., Belfast, Ireland, Univ. of Hull, Eng.) to Campbell River. *Mrs. Josephine Contini* (Red Cross Hosp., Rome, Rome Univ.) to Saanich and So. Vancouver Is. H.U. *Mrs. Helen Mitton* (V.G.H., U.B.C.) to Kitimat. *Julia Meston* (V.G.H., U.B.C.) to Gibsons P.H. Nursing District. *Elizabeth Murray* (Royal Vic. Hosp., Montreal) to Creston. *Beryl Ross* (V.G.H.) to Kelowna. *Lilie Harder* (V.G.H.) to Salmon Arm. *Joan Lewis* (V.G.H.) to Williams Lake. *Yvonne Morris* (King's College, London, Eng.) to Kamloops. *Shirley Main* is returning from her exchange position in Hull, Eng. to Oliver. *Margaret Brown* (Royal Alex. Hosp., Edmonton) to Oliver. *Mary Stewart* (V.G.H.) to Port Alberni. *Mrs. Myrtle Saxton* (V.G.H.) to Alberni Canal. *Fanny Odell* (R.J.H., Victoria) to Powell River. *Dipo Sardar* (Grace Hospital, Winnipeg) to Prince Rupert. *Chizuko Furuya* (Royal Inland Hosp., Kamloops) to Creston.

**Transfers** — *Leola Carr* to Campbell River. *Elizabeth Johnson* to Saanich and So. Vancouver Is. *Alice Pement* to Vernon. *Mary Caryll* to Saanich and So. Vancouver Is. *Hazel Fulmore* to Penticton. *Mrs. Frances (Heugill) Mitchell* to Nelson. *Mary Mc-*



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**Leave of Absence** — *Merry Andreef*, *Jean Fleming*, *Margaret Shepping*, *Chizuko Furuya*, *Helen Havrylak*, *Ruth Haydon*, *Julia Hutton Potts*, *Patricia Todd* have enrolled in the diploma course in public health nursing at U.B.C. *Donalda Ross* has begun postgraduate work at McGill University. *Marion Boyd* is completing advanced study at McGill Univ.

**Resignations** — *Mrs. Gwen (McKee) Hairsine* from Vernon. *Mary Lange* from Kimberley. *Marjorie Blackburn* who has been on exchange from Hull, England, has returned there. *Bernadine Conroy* from Dawson Creek. *Mrs. Clara Nygren* from the Gibsons Public Health Nursing district. *Mrs. Iva Truscott* from Creston. *Mrs. Beryl Sussel* from Ocean Falls. *Patricia Baillie* from Courtenay. *Mrs. Sybil MacFarlane* from Kamloops. *Mrs. Doris Pearson* from Salmon Arm. *Mrs. Shirley LeBrasseur* from Qualicum. *Mrs. Jessica Field* from Nanaimo. *Marilyn Barber* from Abbotsford. *Doreen Pope* from Smithers. *Solvig Carlson* from Terrace. *Mrs. Evelyn Bockhold* from Coquitlam. *Joyce Davies* from Campbell River. *Gertrude Rach* from Vanderhoof to join the R.C.A.F. *Mrs. Kay Allan* from Saanich and South Vancouver Island H.U. to accept a position as public health nursing coordinator at St. Joseph's Hospital, Victoria. *Jorun Skog* from Oliver to join the Indian Health Services. *Mrs. Betty Caruthers* from Nelson. *Mrs. Willa Stevenson* from Quesnel. *Mrs. Thora McLeod* from Castlegar. *Mrs. Shirley Hill* from Prince George.

\* \* \*

The tuberculosis problem is with us per-



haps to an even greater extent than formerly, because we tend to discharge the patient sooner as chemotherapy controls the contagious aspects more quickly.

— DR. H. SHUBIN

\* \* \*

If I have learned anything it is that pity is more intelligent than hatred, that mercy is better even than justice, that if one walks around the world with friendly eyes one makes good friends.

— PHILIP GIBBS

## Ontario

The following is a list of the changes in the Ontario Public Health Services:

**Appointments** — *Edith Rosenow* (Moncton Gen. Hosp., Univ. of Toronto) to Amherstburg Board of Health. *Helen Herron* (Kingston Gen. Hosp., Queen's Univ.) to Belleville B.H. *Elizabeth (Cooke) Hochner*, (Wellesley Hosp., Toronto, U. of T.), *Barbara MacGregor* (Brantford Gen. Hosp., U. of T.) and *Irma von Allmen* (R.V.H. Montreal, McGill Univ.) to Brant Co. Health Unit. *Marie (Henry) Colling* (Victoria Hosp., London, U. of T.) and *Ruth Thompson* (Wellesley Hosp. U. of T.) to Bruce Co. H.U. *Barbara Bowland* (Toronto Gen. Hosp., Univ. of West. Ont.) to Chatham B.H. *Mary Parish* (T.G.H., U. of T.) and *Vera Slocombe* (Hamilton Gen. Hosp., U. of T.) to Dufferin Co. H.U. *Elizabeth (Williams) Hyland* (Hamilton Gen. Hosp. Univ. of West. Ont.) from Peel Co. H.U., and *Patricia Walker* (R.V.H., Montreal, B.Sc. N. Univ. of West. Ont.) to Elgin-St. Thomas H.U. *Adele Fetterly* (Toronto Western Hosp., U. of T.), *Alice Keryluk* (McKellar Gen. Hosp., Fort William, U. of T.) and *Marilyn Deamude* (Hosp. for Sick Children, B.N.Sc. Queen's Univ.) to Fort William San. *Betty Coney* (Misericordia Gen. Hosp., Winnipeg, U. of T.) and *Elizabeth Law* (Hamilton Gen. Hosp., U. of T.) as staff nurse and supervisor respectively to Galt B.H. *Sarah Ann Lambert* (Hamilton Gen. Hosp., Univ. of West. Ont.) to Haldimand Co. School Health Service). *Esther Matheson* (Oshawa Gen. Hosp., Univ. of West. Ont.) to Halton Co. H. U. *Mavis Barker* (B.Sc. Univ. of Alta.) and *Esther Saisho* (Toronto West. Hosp., U. of T.) to Hamilton Dept. of Health. *Jean Falconer* (Kitchener-Waterloo Hosp., Univ. of West. Ont., U. of T.) as supervisor, *Sara Goertzen* (Toronto East Gen. Hosp., U. of T. and *Glennys Mowat* (R.V.H., Montreal, Univ.

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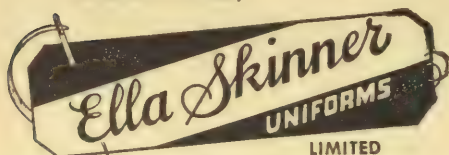
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of West. Ont.) to Huron Co. H.U. *Marjorie Sherk* (Woodstock Gen. Hosp., U. of T.) to Kenora-Keewatin-Dryden Area H.U. *Patricia Graham* (Toronto West Hosp., U. of T.), *Alice McKenzie* (Victoria Hosp., London, U. of T.) and *Jean McKague* (Guelph Gen. Hosp., Univ. of West. Ont.) to Kent Co. H.U. *Marie Doyle* (St. Jos. Hosp., U. of T.) to Lambton H.U. *Marie Metcalfe* (Hôtel Dieu Hosp., Kingston, Univ. of Ottawa), *Sonia Meyer* (Ottawa Civic Hosp., U. of T.) and *Margaret McIntosh* (Belleville Gen. Hosp., U. of West. Ont.) to Leeds and Grenville H.U. *Leora Wright* (Vancouver Gen. Hosp., B.A.Sc. U. of B.C., U. of T.) as supervisor, *Barbara Chick* (Kingston Gen. Hosp., U. of T.) and *Diana Sinclair* (Woodstock Gen. Hosp., Univ. of West. Ont.) to Lennox and Addington H.U. *Frieda (Davidson) Forsberg* (Hamilton Gen. Hosp., Univ. of West. Ont.) to the Middlesex Co. School Health Service. *Ruth Henry* (Brockville Gen. Hosp., U. of T.) and *Margaret Robins* (Women's College Hosp., U. of T.) to Northumberland and Durham H.U. *Marilyn Davidson* (Peterborough Civic Hosp., U. of T.) to Oshawa B.H. *Cora (Spierenburg) Etheridge* (Ont. Hosp., Hamilton, Univ. of West. Ont.) to Oxford Co. H.U. *Louise Martin* (T.G.H., U. of T.) to Peel Co. H.U. *Lorna Nelson* (Owen Sound Gen. and Marine Hosp., U. of T.) and *Ruth (Kidd) Mordaunt* (Hosp. for Sick Children, U. of T.) to Peterborough B.H. *Marie Boisvert* (Univ. of Ottawa), *Isabel Knechtel* (T.W.H., U. of T.) and *Suzanne Tambeau* (St. Jos. Hosp., Hamilton, Univ. of Ottawa) to Porcupine H.U. *Elizabeth Row* (Woodstock Gen. Hosp., Univ. of West. Ont.) to Port Arthur B.H. *Lise Cusson* (Univ. of Ottawa) and *Therese Tremblay* (Sacred Heart Hosp., Hull, Univ. of Ottawa) to Prescott & Russell H.U. *Goldie (Duncanson) Anglin* (St. Jos. Hosp., London, Univ. of West. Ont.) to Prince Edward Co. H.U. *Kathleen Barry* (H.S.C., Toronto, Univ. of West. Ont.), *Gwen Pirie* (Hamilton Gen. Hosp., Univ. of West. Ont.) and *Susan Reimer* (Hamilton Gen. Hosp., Univ. of West. Ont.) to St. Catharines-Lincoln H.U. *Dorothy Gibson* (St. Jos. Hosp., Hamilton, U. of T.) to Sault Ste. Marie B.H. *Elizabeth McCarthy* (W.C.H., Toronto, U. of T.), *Jean MacPhail* (T.W.H., U. of T.) and *Laura (Dousett) Willard* (Queen Elizabeth Hosp., Montreal, U. of T.) to Simcoe Co. H.U. *Mary (Sheller) Coome* (Chatham Gen. Hosp., U. of T.), *Shirley (Gaffney) Marks* (O.C.H., Univ. of West. Ont.), *Lucille Pilon* (Univ. of Ottawa), *Myra Rumsey* (H.S.C., Toronto, McGill Univ.) *Kathleen Terrill*

(Hamilton Gen. Hosp., U. of T.) and *Patricia Upshall* (St. Michael's Hosp., Toronto, U. of T.) to Stormont, Dundas and Glengarry H.U. *Marge Grace* (St. Michael's Hosp., U. of T.) to Sudbury B.H. *Marjorie Coristine* (W.C.H., U. of T.), *Susie Janzen* (Greater Niagara Gen. Hosp., Univ. of West. Ont.) and *Yolande Jolicoeur* (Sacred Heart Hosp., Hull, Univ. of Ottawa) to Timiskaming H.U. *Margaret McElheran* (W.C.H., Toronto, U. of T.) as supervisor, Toronto Dept. of P.H. *Mildred McMartin* (McKellar Gen. Hosp., Ft. Wm., Univ. of West. Ont.) to Welland and District H.U. *Betty Miller* (Orillia Soldier's Mem. Hosp., U. of T.), *Christena Miller* (Children's Hosp. of Michigan, U. of T.), and *Margaret Pigden* (Belleville Gen. Hosp., U. of West. Ont.) to Wellington Co. H.U. *Carrie Genik* (Royal Alex. Hosp., Edmonton, U. of T. as supervisor, *Joanne Donald* (T.G.H., U. of T.), *Margaret (McPhail) Harrison* (St. Jos. Hosp., Sudbury, Univ. of Ottawa), *Betty McLaren* (Galt Gen. Hosp., U. of T.), *Nobuko Oikawa* (W.C.H., U. of T.) to Wentworth Co. H.U. *Dorothy (Taylor) Loucks* (Winnipeg Gen. Hosp., U. of T.) to Windsor Dept. of Health. *Cora Lango* (Wellesley Hosp., U. of T.) from St. Catharines-Lincoln H.U. and *Freda (Tomlinson) McKillop* (Sarnia Gen. Hosp., U. of T.) to York Co. H.U. *Mary (Ankcorn) Brunton* (Owen Sound Gen. and Marine Hosp., U. of T.) and *Nora Yeo* (U. of T.) as staff nurse and supervisor respectively of York Township B.H.

**Resignations** — *Mary Pickens* from Belleville B.H. *Joan Cormack* from Bruce Co. H.U. *Grace (Scott) Shackell* from Dufferin Co. H.U. *Patricia Pietersma* from Elgin-St. Thomas H.U. *Jane Minott* from Haliburton Co. School Health Service. *Mary Petrone* from Fort William and District H.U. *Jean Humphrey* from Kenora-Keewatin-Dryden Area H.U. *Joan Sutherland* from Leeds and Grenville H.U. *Ethel Tingley* from Lennox and Addington H.U. *Maida Harris* and *Audrey Wale* from Northumberland and Durham H.U. *Madalyn (Holmes) Montgomery* from North York Township B.H. *Gaetane Laroque* and *Jean McLaren* from Porcupine H.U. *Fernande Dion* from Prescott and Russell H.U. *Irene Nealon* from St. Catharines-Lincoln H.U. *Patricia (Ball) Kealy*, *Marguerite (Edwards) Dupuis* and *Dorothy Montgomery* from Stormont, Dundas & Glengarry H.U. *Margaret Anderson* and *Helen Etherington* from Wentworth Co. H.U. *Edith (Munroe) Thompson* from Windsor B.H. *Helen (Elliot) Kennedy* from York Township B.H.

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# News Notes

## BRITISH COLUMBIA

### LADYSMITH

The first chapter meeting of the season was held early in September at the nurses' residence, with an attendance of ten. E. Anderson from Denmark and E. Wolf who recently joined the public health staff of the area were welcomed. K. Bailey, matron of the West Coast Hospital, Port Alberni was the guest speaker at the Vancouver Island District meeting in October.

### VANCOUVER

#### *St. Paul's Hospital*

The appointment of Winifred E. Taylor to a position on the faculty of the Boston University School of Nursing was recently announced. Miss Taylor did private nursing in Canada for a short time before accepting a position with Beverly Hospital, Beverly, Mass. While there she served first as surgical instructor before becoming nursing arts instructor — a post she retained for five years. In 1955 she obtained her B.Sc. degree in nursing from Boston College. During the past year she has been a teaching fellow at Boston University while completing studies for her master's degree in nursing education. She was one of a group of five who chose rehabilitation as a major area of study.

## ONTARIO

### DISTRICT 5

### TORONTO

#### *Western Hospital*

Diplomas were presented to seventy-nine nurses at the graduation exercises of the Atkinson school of nursing in September. The guest speaker for the occasion was Mr.

## FOR SALE

### ELMIRA PRIVATE HOSPITAL

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*For further information apply:*

**ELMIRA PRIVATE HOSPITAL, ELMIRA, ONTARIO**



W. Harris, Minister of Finance.

G. Sharpe has been appointed chairman of the nursing committee, Ontario Division, Canadian Red Cross Society.

### *Women's College Hospital*

A supper meeting in Burton Hall early in September initiated the season's activities of the alumnae association. A theatre night is to be sponsored later in the season.

Miss Mullen has assumed charge of the operating room. She had previously been with the United Mission Hospital for several years. Miss Simms has returned to the staff following postgraduate study at Columbia University. At this year's graduation ceremony, Doreen Hood received the Mary F. Bowman award for general proficiency.

## QUEBEC

### MONTREAL

### *Royal Victoria Hospital*

B. Pratt has joined the staff of the Main building as clinical supervisor. M. Vice is a member of the Nursing School Office, Women's Pavilion. S. Osborne is on the staff of the Kirkland and District Hospital, Kirkland Lake. V. Wright is presently with the University of California Medical Centre, San Francisco.

M. Clark, C. Lidstone, D. Arthurs, H. Cilinski and M. Patterson are enrolled in postgraduate study with the School for Graduate Nurses, McGill University. Recent visitors to the hospital have been: A. (Routledge) Draper, L. (McKinnon) Hagberg, M. Baker, A. Muggah and S. Dawson who is presently studying theology at the Toronto Bible College.

## SASKATCHEWAN

### SASKATOON

### *St. Paul's Hospital*

At a gathering of the members of the faculty and the students, 50 young ladies were formally welcomed to the school of nursing in September. The warm welcoming remarks of the chairman, D. Wolfe, were endorsed by the president of the Student Council, G. Peterson, and the president of the Sodality, B. Andreas. The musical program which followed included the traditional class songs. The introduction of the new students by their respective "big sisters" was the main event of the evening. Mrs. Grace Millar, secretary of the Saskatchewan Unit of the Florists Telegraph Delivery Association, presented the annual awards of this association. M. Kammermayer was given the third year student award for the highest standing in theory at the annual graduation exercises earlier this year. F. Aden and R. Ringnose received the second year and first year awards. The singing of the school song and a social hour concluded a pleasant welcoming party.



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U.S.A. & Foreign — \$7.50 for 3 lines or less; \$1.50 for each additional line.

Closing date for copy and cancellations: 10th of the month preceding the month of publication. All letters should be addressed to: The Canadian Nurse, 1522 Sherbrooke St. W., Montreal 25, Que.

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**Superintendent of Nurses (1).** Salary: \$275 per mo. **Graduate Nurses (2).** Salary: \$235 per mo. less \$40 per mo. room, board & laundry. 28-bed hospital, pleasant surroundings, 5 mi. from U.S. border. 40-hr. wk., 4 wk. vacation after 1 yr. service. 1½ days sick leave per mo., yearly accumulative. Nice nurses' residence. Apply The Grands Forks Community Hospital, Grand Forks, B.C.

---

**Graduate Nurse (experienced),** capable of assuming position of **Superintendent of Nurses** in new, modern, 25-bed hospital. Required immediately. **Graduate nurses (2)** to complete staff. Salary scale according to R.N.A.B.C. policies. Board & room, \$35 per mo. Apply, Administrator, Lady Elizabeth Bruce Memorial Hospital, Invermere, B.C.

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**Matron (November 1st) for 27-bed Community Hospital.** Salary: \$300 per mo. 40-hr. wk. 28 days vacation after 1 yr. service, all statutory holidays paid. Room, board & laundry \$40. Good knowledge of X-ray essential. Apply, giving full details to Sec., Slocan Community Hospital, New Denver, B.C.

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**Superintendent of Nurses** for modern 80 bed hospital required immediately. Operating room Supervisor & Registered Nurses for general duty. Good personnel policies and salary for fully qualified nurses. Apply, stating qualifications and experience, to Administrator, Portage Hospital District No. 18, Portage La Prairie, Man.

---

**Superintendent of Nurses for 53-bed hospital.** Fully accredited & offering ideal working conditions to a qualified Registered Nurse. Salary: \$225 plus full maintenance & apt. in new nurses' residence. Excellent personnel policies. 1 mo. annual vacation. Apply Secretary, Kentville Hospital Assoc., Kentville, Nova Scotia.

---

**Superintendent of Nurses for 22-bed hospital.** Good salary offered. Increments every 6 mo. for 3 yrs. Living accommodation in separate modern nurses' residence. Home equipped with automatic heating & hot water. 1 mo. vacation after 1 yr. employment. Statutory holidays extra. Cumulative sick leave to 90 days. No business matters to handle such as book-keeping, purchasing, admissions, collection of accounts. Apply in writing or phone Sec.-Manager, Union Hospital, Hafford, Sask.

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**Matron for modern 8-bed hospital.** Salary: \$285 per mo., less \$30 for full maintenance. Apply stating experience to Sec.-Treas., Union Hospital, Hodgeville, Saskatchewan.

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**Director of Nurses for 250-bed hospital with school of nursing.** Suite in nurses' residence, full maintenance. Good personnel policies. Apply, stating salary expected, age, qualifications, training & experience to Administrator, Union Hospital, Moose Jaw, Sask.

---

**Director of Nursing for 185-bed JCAH accredited General Hospital,** Protestant Church affiliated. NLN temporary accredited school of nursing, 75 students. Addition to hospital under construction. Must have B.S. degree in nursing & preferably an M.A. in nursing. Good salary, furnished apt., position open early winter. Apply Administrator, Evangelical Deaconess Hospital, 3245 E. Jefferson Ave., Detroit 7, Michigan.

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**Assistant Director of Nursing, Head Nurse, General Duty Nurses for 150-bed Hospital.** 44-hr. wk. 31-days vacation plus statutory holidays, 2-wks. sick leave yearly. Write stating qualifications, salary expected, age & references to Director of Nursing, Grace Dart Hospital, 6085 Sherbrooke St. E., Montreal, Que.

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**Night Supervisor.** Salary: \$2,760-\$3,300 plus cost-of-living bonus approximating \$325 per annum. Excellent holiday, sick leave and pension benefits. Apply to Baker Memorial Sanatorium, Calgary, Alberta.

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**Supervisor,** starting salary: \$225. Must be registered in British Columbia. **Operating Room Nurses,** salary: \$230 plus \$10 'on call,' \$10 postgraduate. **Charge Nurses,** salary: \$245. **General Duty Nurses,** salary \$230. Additional salary paid to nurses with 2 yrs. past experience, plus 4 annual increments to \$40. 28 days vacation, 10 statutory holidays. 1½ days sick leave, cumulative. Room rent at nurses' residence \$20 per mo. Apply Director of Nursing, Trail-Tadanac Hospital, Trail, B.C.



# NURSING WITH INDIAN AND NORTHERN HEALTH SERVICES



## OPPORTUNITIES FOR REGISTERED HOSPITAL NURSES, PUBLIC HEALTH NURSES, and NURSING ASSISTANTS or PRACTICAL NURSES

for Hospital Positions and Public Health Positions in Outpost Nursing Stations, Health Centres and Field Positions in the Provinces, Eastern Arctic and North-West Territories.

### SALARIES



- (1) Public Health Nursing Supervisors: up to \$4,620 depending on qualifications and location.
- (2) Directors of Nursing in Hospitals: up to \$4,620 depending on qualifications and location.
- (3) Public Health Staff Nurses: up to \$3,600 per year depending on qualifications and location.
- (4) Hospital Staff Nurses: up to \$3,420 per year depending upon qualifications and location.
- (5) Nursing Assistants or Practical Nurses: up to \$185 per month depending upon qualifications and location.

- Room and board in hospitals — \$30 per month. Statutory holidays. Three weeks' annual leave with pay. Generous sick leave credits. Hospital-medical and superannuation plans available.

- Special compensatory leave for those posted to isolated areas.

For interesting, challenging, satisfying work, apply to — Indian and Northern Health Services at one of the following addresses:

- (1) Regional Superintendent, 4824 Fraser Street, Vancouver 10, B.C.
- (2) Regional Superintendent, c/o Charles Camshell Indian Hospital, Edmonton, Alberta.
- (3) Regional Superintendent, 735 New Federal Building, Regina, Saskatchewan.
- (4) Regional Superintendent, 522 Dominion Public Building, Winnipeg 1, Manitoba.
- (5) Zone Supervisor of Nursing, Box 292, North Bay, Ontario.
- (6) Zone Supervisor of Nursing, P.O. Box 3427, St. Roch Branch, Quebec, Que.
- (7) Moose Factory Indian Hospital, Moose Factory, Ontario.

or

Chief, Personnel Division, Department of National Health and Welfare, Ottawa, Ontario.



**Supervisor of Nursing Service for 50-bed active General Hospital.** Salary: \$210 plus maintenance with 6 monthly bonuses of 5%. 44-hr. wk. 10 statutory holidays & after 1 yr. on staff vacation of 21 days & sick time allowance of 14 days. For further information apply Miss M. Jarvis, Matron, Municipal Hospital Dist. #17, Wainright, Alta.

**Supervisor for Pediatrics Dept.** with postgraduate course or equivalent. Contract conforms with R.N.A.B.C. personnel practices. Apply Director of Nurses, General Hospital, Chilliwack, B.C.

**Supervisor of Nursing (R.N. experienced in nursing service administration desirable) for new modern 50-bed General Hospital** in progressive town (10,000) in Cariboo Dist. central B.C. 14 R.N.'s., 10 Aides, 6 Med. staff. Priv. suite in new residence. Salary commensurate with qualifications. 40-hr. wk., 28 days vacation plus 10 statutory holidays. Sick leave. Travel allowance. Please state age, salary expected, experience & references to Administrator, G. R. Baker Memorial Hospital, Quesnel, B.C.

**Operating Room Supervisor** for 110-bed hospital. Apply, Superintendent, Charlotte County Hospital, St. Stephen, N.B.

**Supervisors & Staff Nurses.** Good salary & personnel policies. Living accommodations available. Apply Director of Nurses, General Hospital, Parry Sound, Ontario.

**Night Supervisor, Assistant Head Nurses & Staff Nurses.** Excellent personnel policies. Apply Director. Shriner's Hospital for Crippled Children, 1529 Cedar Ave., Montreal, Que.

**Evening Supervisors, Registered Nurses, Catherine Booth Graduates, Nursing Assistants for 68-bed hospital, 68 mi. from Montreal.** Excellent bus & train service. Salaries are in accordance with A.N.P.Q. Full maintenance. 8-hr. duty, rotating shift. 1½ days off per wk. 30 days annual vacation. Sick leave allowance. Blue Cross hospitalization paid by hospital. Apply Supt., Brome-Missisquoi Perkins Hospital, Sweetburg, Que.

**Operating Room Supervisor for 118-bed General Hospital located in a beautiful residential suburb along the North Shore of Chicago.** Modern ranch style nurses' homes with attractively furnished private bedrooms. 40-hr. wk. Apply Director of Nursing Services, Highland Park Hospital Foundation, Highland Park, Illinois.

**Instructor** for school of nursing — Applications are invited for 138-bed hospital. This school is affiliated with Montreal hospitals, the teaching schools associated with McGill University. For particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

**Head Nurses for 340-bed hospital for chronic illness & rehabilitation.** Ontario registration & membership in R.N.A.O. required. Gross salary: \$250 plus fringe benefits. 3 annual increments. 40-hr. wk. 3 wk. vacation, 8 statutory holidays, cumulative sick leave. Apply Director of Nursing Services, Riverview Hospital, Windsor, Ont.

**Registered Nurses or Non-Registered Nurses if recent graduates (4) for very active 50-bed hospital.** Salary: \$180-\$185 depending on experience, plus complete maintenance & laundering of uniforms. \$5.00 increase every 6 mo. to a maximum of \$200 & 5% bonus every 6 mo. 88-hr. fortnight with rotating 8-hr. shifts. 10 statutory holidays & after 1 yr. on staff vacation of 21 days & sick time allowance of 14 days. For further information apply Miss M. Jarvis, Matron, Municipal Hospital District #17, Wainright, Alta.

**Registered Nurses (2) for new 30-bed hospital.** Apply Matron, Creston Valley Hospital, Creston, British Columbia.

**Registered General Duty Nurse for 18-bed hospital by December 15th.** Starting Salary \$225 per mo., \$5.00 increment every 6 mo. 5 day wk., 10 statutory holidays. Nurses' residence room & board \$40 per mo. Apply Matron, Lady Minto Hospital, Ganges, B.C.

**Registered Nurses.** Single room residence. \$225 per mo. gross. 5 day wk. 20 mi. east of Toronto. Apply Supt. Ajax & Pickering General Hospital, Ajax, Ont.

**Registered Nurses.** Gross salary for nurses currently registered in Ont. \$235 per mo. Good personnel policies. New facilities. Comfortable nurses' residence. 8-hr. rotating shift. 44-hr. wk. 1 day off 1 wk., 2 the next. 1½ days holiday allowed per mo. same sick time accumulated to 90 days. 8 legal holidays per yr. The equivalent of single train fare paid up to \$40 after 1 yr. service. Apply Supt., Lady Minto Hospital, Cochrane, Ont.

**McKellar General Hospital, Fort William, Ont. requires Registered General Duty Nurses.** Good personnel policies. Residence accommodation available at reasonable rates. Hospital has recently completed a well equipped & staffed wing with extensive renovation program progressing in the old section. Apply Director of Nursing.

**Registered Nurses for General Duty.** Initial salary: \$200 per mo.; with 6 or more months Psychiatric experience, \$210 per mo. Salary increase at end of 1 yr. 44-hr. wk.; 8 statutory holidays, annual vacation with pay. Living accommodation if desired. For further information apply Supt. of Nurses, Homewood Sanitarium, Guelph, Ont.

# 50 Nurses Needed...

## HAMILTON, ONTARIO

*The three city-owned hospitals, the General, the Mountain with its maternity wing and the Nora-Frances Henderson, have recently undergone an expansion program and are in immediate need of a minimum of 50 Registered Nurses.*



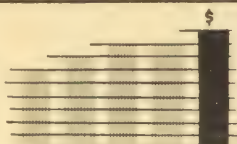
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Situated in the heart of what has been termed the "Golden Horseshoe", Hamilton is a city practically equidistant to Toronto and Buffalo, big enough to be interesting, yet small enough to be friendly and hospitable to the individual.



The rates of pay to Registered Nurses are the highest in the Province of Ontario. For Registered Nurses who work rotating hours of service, the beginning salary is \$53.00 per week. The daily rate is \$10.50 for each eight-hour period of duty.



Hours of duty: (a) 8 hour day—42 hours weekly average—rotating service. DAYS: 7 a.m. to 3.30 p.m. or 10 a.m. to 7 p.m.; EVENINGS: 3 p.m. to 11.30 p.m.; NIGHTS: 11.15 p.m. to 7.15 a.m. These schedules include one half hour for each meal and 15 minutes for morning coffee. (b) Two days off three successive weeks and one day off every fourth week. (c) All statutory holidays or compensatory time.



VACATIONS: Registered Nurses after one year of service receive 3 weeks vacation with pay. It is less than 200 miles to the beautiful Muskoka Lakes District, less than 2 hours to the U.S. border.



Here is a unique opportunity for Registered Nurses to come to a thriving community where your opportunities are unlimited.  
For further particulars write:

**HAMILTON GENERAL HOSPITAL**  
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Hamilton, Ontario



**Registered General Duty Nurses for 200-bed General Hospital.** Salary: \$220 per mo. 5½ day wk. Good personnel policies. Apply Director of Nursing, General Hospital, Sault Ste. Marie, Ontario.

**Registered General Duty Nurse for active 18-bed hospital.** Good salary. Vacation with pay, statutory holidays & sick leave allowance. Apply Administrator, District Hospital, Shelburne, Ontario.

**Registered General Duty Nurses for 200-bed hospital in the Niagara Peninsula.** Gross salary: \$215, afternoons — \$225, nights — \$220. Annual increments. 44-hr. wk. 3-wk. vacation per yr., 8 statutory holidays. Cumulative sick leave. Accommodation available in attractive residence. Apply Director of Nursing, County General Hospital, Welland, Ont.

**Registered Nurses for modern 60-bed General Hospital** situated 40 mi. south of Montreal. Salary: \$200 per mo., additional monthly bonus for permanent evening & night shifts. 44-hr. wk., 8-hr. duty. Many attractive benefits provided. Board & accommodation available at minimum cost in completely new motel-style nurses' residence. Apply Supt., Barrie Memorial Hospital, Ormstown, Que.

**Registered Nurses (2) for modern 8-bed hospital.** Salary: \$240 per mo., less \$30 full maintenance. For further information apply B.E.L. Magnusson, Sec-Treas., Union Hospital, Hodgeville, Saskatchewan.

**General Duty Registered or Graduate Nurses (2) for modern 20-bed hospital.** Salary: \$220 (Graduate), \$230 (R.N.). Increment of \$5.00 after each 6-mo. service. 1 mo. vacation with pay after 1 yr. service. \$30 per mo. maintenance. Separate staff residence. Apply Matron, Riverside Memorial Hospital, Turtleford, Sask.

**Registered Nurses for 8-bed hospital. Straight 8-hr. shift.** Gross salary: \$240-\$260 depending on experience. For further information apply Sr. Superior, Notre Dame Hospital, Val Marie, Saskatchewan.

**Registered Nurses. Male & Female.** Starting salary: \$300 up, plus \$10 pm shifts. 40-hr. wk., paid vacation, 10 days sick leave. Social Security, hospital group ins. Apply Mr. Glenn A. Dickau, R.N., Administrator, Memorial Hospital, Corning, California.

**Registered Nurses for charge duty.** Starting salary: \$250 per mo., increase of \$5.00 every 6 mo. to max. of \$275. Evening & night duty \$10 per mo. extra. 40-hr. wk. 2 wk. paid vacation after 1 yr. 6 paid holidays. Meals while on duty. Nurses' home completely furnished, including linen & laundry available for \$30 per mo. Apply County Memorial Hospital, Gooding, Idaho.

**Registered General Duty Nurses for 118-bed General Hospital** along the shores of Lake Michigan, 25 mi. from Chicago. Base salary: \$300. Additional differential of \$30 for evenings & \$20 for nights. 5 day wk. Good personnel policies. Apply Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

**Registered Nurses for Medical-Surgical, Psychiatric, Obstetrical & Pediatric Units, 325-bed, air-conditioned hospital.** Starting salary: \$265 with bonus for evening & night duty. 40-hr. wk. Liberal personnel policies, low cost cafeteria, free laundry. Apply Director of Nursing, Menorah Medical Center, 4949 Rockhill Rd., Kansas City, Missouri.

**General Duty Nurses and Nursing Aides.** Active 700-bed general hospital. From September 1. Good working conditions. Personnel policies upon request. For further particulars apply to Director of Nurses, Royal Alexandra Hospital, Edmonton, Alta.

**General Duty Nurse for 17-bed hospital.** Starting salary: \$200 gross. 1 mo. vacation with pay after 1 yr. service. \$5.00 per mo. increase after each 6 mo. service up to 3 increases. Transportation refunded after 6 mo. service. Apply Municipal Hospital, Elnora, Alberta.

**General Duty Nurses.** Salary: \$230-270, \$10 increment for experience. 40-hr. wk. 1½ days sick leave per mo. cumulative; 10 statutory holidays, 1 mo. vacation. Must be eligible for B.C. registration. Apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

**General Duty Nurses for 430-bed hospital; 40 hr. wk.** Statutory holidays. Salary \$240-\$273. Credit for past experience. Annual increments; cumulative sick leave; 28 days annual vacation; B.C. registration required. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

**General Duty Nurse for well equipped 80-bed General Hospital** in beautiful inland valley adjacent Lake Kathryn. Boating, fishing, swimming, golfing, curling, skiing. Initial salary: \$240. Full maintenance \$40. 44-hr. wk., vacation with pay. Comfortable, attractive nurses' residence on grounds. Rail fare advanced if necessary. References required. Apply Bulkley Valley District Hospital, Smithers, B.C.

**General Duty Nurses (Immediately) for 500-bed hospital.** Attractive personnel policies. Apply Director of Nurses, St. Joseph's Hospital, Victoria, B.C.

**Royal Jubilee Hospital, Victoria, B.C.** invites applications for **General Duty Nurses** for permanent positions & vacation relief in 500-bed General Hospital. Salary \$227.50-\$262.50 5-day, 40-hr. wk. 4-wk. vacation. 10 statutory holidays. Pension plan. Attractive employee benefits. Apply, Director of Nursing.



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CN-11-56

# Royal Canadian Navy

**General Duty Nurses for Medical, Surgical, Pediatrics, Obstetrics.** Good salary & personnel policies. Apply Director of Nursing, Victoria Hospital, London, Ont.

---

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---

**General Duty Nurses (3), O.R. Scrub Nurse for new 143-adult bed plus 30-bassinette hospital.** Good personnel policies. Starting salary: \$215 per mo. Apply Director of Nurses, Plummer Memorial Hosp., Sault Ste. Marie, Ontario.

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**General Duty Nurses for 60-bed General Hospital.** Good salary & personnel policies. 44-hr. wk. All statutory holidays. Sick leave allowance. Apply Supt., Public Hospital, Smiths Falls, Ontario.

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**General Duty Nurses as soon as possible.** Gross starting salary: \$225 per mo. with automatic increases semi-annually for 2 yrs. 44-hr., 5½ day wk. 1 mo. vacation with pay after 1 yr. service. All statutory holidays. Separate nurses' home. For further information apply to the Matron, Lloydminster Hospital, Lloydminster, Sask.

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**General Duty Nurses for 466-bed hospital.** Salary: \$300 California registered, \$270 Canadian registered. \$15 differential for 3-11 & 11-7 shifts. Apply Cedars of Lebanon Hospital, 4833 Fountain Ave., Los Angeles, California.

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**General Duty Nurses for 650-bed teaching hospital in central California.** Salary: \$288-\$337 per mo. 40-hr. wk. Liberal vacation, holiday & sick leave plan. Apply Personnel Office, 510 E. Market St., Stockton, California.

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**General Staff Nurses** for 400-bed Medical & Surgical Sanatorium, fully approved student affiliation & postgraduate program. Full maintenance. Recreational facilities. Vacation with pay. Sick benefits after 1 yr. Blue Cross coverage. Attractive salary; 40-hr. wk. For further particulars apply Supt. of Nurses, Nova Scotia Sanatorium, Kentville, N.S.

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**Staff Nurses for 600-bed General & Tuberculosis Hospitals with student programs.** In central valley, city of 108,000. State & Junior Colleges afford opportunity for advanced education. Salary \$300 with 4 annual increases to \$341. Full maintenance \$45 per mo. Liberal personnel policies. Apply Assoc. Director of Nursing Service, County General Hospital, Fresno, California.

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---

**Staff Nurses for 500-bed General Hospital.** Beginning salary: \$300 per mo. with advancement to \$335 for those eligible for registration in the state of Michigan. Additional differential \$1.50 per afternoon or night. 40-hr. wk. Hospital & school of nursing fully approved. Apply Director of Nursing, The Grace Hospital, 4160 John R. St., Detroit 1, Michigan.

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---

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**Graduate Nurses** for new, very modern 88-bed hospital in a pleasant progressive town. Nurses salary: \$200 per mo. Annual increase \$10 per mo. for 3 yrs. 2-wk. shift rotation, bonus for night shifts. 1 hr. drive to Toronto & several resorts. Local swimming pool, bowling alleys, skating, theatres etc. Apply Director of Nursing, Dufferin Area Hospital, Orangeville, Ont.

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**Public Health Nurse Grade 1.** British Columbia Civil Service, Dept. of Health & Welfare. Starting Salary \$255, \$260, \$266 per mo., depending on experience, rising to \$298. per mo. Promotional opportunities available. Qualifications: Candidate must be eligible for registration in British Columbia & have completed a University degree or Certificate course in Public Health Nursing. (Successful candidates may be required to serve in any part of the Province.) Cars are provided. 5-day wk. in most districts. Uniform allowance. Candidates must be British subjects; preference is given to ex-service women. Application forms obtainable from all Government Agencies, the Civil Service Commission, 544 Michigan St., Victoria, or 411 Dunsmuir St., Vancouver 3, to be completed & returned to the Chairman, Civil Service Commission, Victoria. Further information may be obtained from the Director, Public Health Nursing, Dept. of Health & Welfare, Parliament Bldgs., Victoria, B.C.

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Responsible for classroom and clinical instruction in pediatric nursing & co-ordinating maternal & child care program in school where organizational set-up permits stressing of patient-centred care and student-centred learning activities.

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**Public Health Nurse (Qualified) for generalized program.** Salary: \$3,000-\$3,600 depending on experience. Annual increment \$150. 5-day wk. Pension plan. Blue Cross & P.S.I. available. Car provided or car allowance. Apply Dr. Charlotte M. Horner, Director, Northumberland-Durham Health Unit, Cobourg, Ont.

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**Public Health Nurses (qualified.)** Salary: \$3,100 depending on dist. served, less if in the Timmins area. Annual increment \$150 per annum for 4 yrs. Additional allowance for experience & if French-speaking. 5-day wk. 4-wk. vacation, 18 days sick leave annually (cumulative.) Car is provided. Half cost of uniform is allowed & half of Blue Cross. Workmen's Compensation. Good working conditions. Apply Sec.-Treas., Porcupine Health Unit, 164 Algonquin Blvd. E., Timmins, Ont.

**Public Health Nurses (Qualified) for a generalized program in Etobicoke Township (suburb of Toronto.)** Minimum salary: \$3,200. Annual increments to \$3,680. Starting salary based on experience. Car allowance \$670 per annum. 4 wk. vacation after 1 yr. Blue Cross & Pension Plan. Apply Director of Public Health Nursing, Township of Etobicoke 4946 Dundas St. W., Toronto 18, Ont.

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— *Scope*

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at

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# THE CANADIAN NURSE

## *L'Infirmière Canadienne*

VOLUME 52

NUMBER 12

DECEMBER 1956

- 942** NEW PRODUCTS
- 949** CHRISTMAS IN KOREA.....*Helen G. McArthur*
- 951** A PEDIATRIC WORK CONFERENCE.....*Madeleine Flander*
- 951** PROCESS NOTES ON THE  
WORK CONFERENCE.....*Hedley G. Dimock*
- 955** THE PEDIATRIC SETTING.....*Alan Ross*
- 957** THE CHILD IN HOSPITAL.....*Jeanne E. Faughnan*
- 959** THE STUDENT NURSE IN A PEDIATRIC  
SETTING.....*Hyman Caplan and Hedley G. Dimock*
- 966** SOME THOUGHTFUL CONCLUSIONS.....*M. Flander*
- 968** LE SOIN DES ENFANTS.....*Suzanne Giroux*
- 971** STAPHYLOCOCCAL PNEUMONIA.....*Clara Demko*
- 974** A GREENHORN ON THE FRONTIER.....*Ruth E. Evans*
- 976** NURSING PROFILES
- 978** IN MEMORIAM
- 981** NURSING ACROSS THE NATION
- 984** ANNUAL MEETING IN P.E.I. .........*H. L. Bolger*
- 986** LE NURSING À TRAVERS LE PAYS
- 990** BOOK REVIEWS
- 992** SÉLECTION
- 992** NEWS NOTES
- 1002** EMPLOYMENT OPPORTUNITIES

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Carnation Research Laboratory; Carnation Farms; Carnation Plant Laboratories; Carnation Central Product Control Laboratory; Carnation-sponsored University & Association Research.



"from Contented Cows"

966

# Between Ourselves

We heartily welcome **Helen G. McArthur** as our guest editor this month. The national director of nursing service with the Canadian Red Cross Society spent Christmas 1954 in Korea where, for nearly eighteen months, she served as liaison and coordinator, guiding the newly organized Korean Red Cross in its first eager steps. Since her return to Canada just a year ago, Miss McArthur has filled a seemingly endless round of speaking engagements. Thousands of Canadian nurses have been enthralled by her vivid word pictures as well as interested in the hundreds of actual photographs that she took.

Our cover picture is from one of Miss McArthur's negatives. A short time before Christmas, 1954, a consignment of hot water bottles and warm bathrobes was shipped by the Canadian Junior Red Cross to Korea for the children who were patients at the Inchon Sanatorium. The big bundles arrived at the time of the first heavy snowfall and the gifts were distributed to the children as part of their Christmas. For a small, tuberculous child, a cuddly bathrobe and his own hot water bottle to tuck into bed with him at night, were welcome gifts indeed.

\* \* \*

Volume 52 closes with this issue. Early in the new year, the **Index** of all of the material that has been published during 1956 will be ready. Several years ago the policy was established of including request coupons in the December and January issues so that any nurse desiring to have a copy of the Index might ask to have one sent to her. If you turn to page 943 you will find the coupon. There is no charge for the Index. Please send in your order early so that we may have some guide regarding the number of copies that will be needed. Schools of nursing, university and public libraries automatically are mailed copies of the Index so no request is necessary.

\* \* \*

How does a student nurse react to the new and different environment of the pediatric department in a large general hospital or to affiliation in a separate children's hospital? What problems do parents face when they have to take their child to hospital? Apart from the care of his physical discomfort

and disability, what different kind of handling does the child patient require?

These and numerous other aspects of **pediatric nursing** formed the topics for discussion at a special conference convened by the Montreal Children's Hospital. While the information each report contains is exceedingly useful the whole project has such merit that it is to be hoped comparable groups in other communities will follow the example and plan a similar kind of conference. When you do, incidentally, don't forget to share the papers with the rest of us through the pages of *The Canadian Nurse*.

\* \* \*

Moving day for the Registered Nurses' Association of Ontario came around at the end of last month. Hereafter, all association business, including registration, membership renewals, committee meetings, etc., will be conducted in the large, comfortable accommodation that is located at **33 Price Street, Toronto 5, Ont.**

Our congratulations to the R.N.A.O. May the work of the Association thrive mightily now they are in their very own building! We hope to have a description of it to share with all our readers, as early as possible next year.

\* \* \*

How do you like the new **type-face** we are using for our article titles? We were awfully tired of the heavy blackness of the type-face we had for several years so did a little experimenting. We think the new, thinner type an improvement, don't you?

\* \* \*

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# New Products

Edited by DEAN F. N. HUGHES

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## BARBIDEX

**Manufacturer**—Elliott-Marion Company Ltd., Montreal.

**Description**—Each three-coloured tablet provides: Dextro-amphetamine sulphate 15 mg., amobarbital 100 mg.

Each layer of the tablet is prepared for release at varying intervals: one-third at once, one-third in four hours, and the balance in eight hours.

**Indications**—To provide therapeutic effects over 10 to 12 hours from one dose, in emotional instability, depressive states, nervous tension, etc.

**Administration**—One tablet on arising.

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## CALCIDRINE SYRUP WITH CODEINE

**Manufacturer**—Abbott Laboratories, Ltd., Montreal.

**Description**—Each 30 cc. (fluid ounce) contains: Codeine phosphate  $\frac{1}{3}$  gr., nembutal sodium  $\frac{3}{8}$  gr. in a palatable, aromatic syrup.

**Indications**—A new, improved formula, flavor and color. Apricot-flavored, highly acceptable and highly effective for cough due to colds. Mucous liquefying, antispasmodic, sedative and inhibitory to the cough reflex.

**Administration**—Adults, 1 to 2 teaspoonfuls every 2 to 4 hours; children 6 to 10 years of age, 1 teaspoonful; children under 6 years of age, only as directed by the physician.

---

## COLISYL PLAIN

**Manufacturer**—Charles E. Frosst & Co., Montreal.

**Description**—Each scored tablet contains: Colisone (prednisone) 0.5 mg., acetylsalicylic acid 325 mg.

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**Administration**—Initially 1 to 3 tablets immediately before meals and at bedtime. After remission has been obtained, the dose should be progressively reduced to a maintenance level. This may be as little as 1 tablet 3 times a day.

---

## DEBILINE-HOMATROPINE

**Manufacturer**—Nadeau Laboratory Limited, Montreal.

**Description**—Each tablet contains: Desoxycholic acid 0.15 gm., homatropine methylbromide 2.5 mg.

**Indications**—As a choleric, to increase hepatic activity, and as an antispasmodic.

**Administration**—One or two tablets, 2 or 3 times a day according to desired effect.

---

## DENABYL

**Manufacturer**—J. M. Marsan & Co. Limited, Montreal.

**Description**—Each tablet contains: Dehydrocholic acid 300 mg., homatropin (methyl bromide) 1.5 mg., choline bitartrate 150 mg., dl-methionine 100 mg.

**Indications**—Conditions due to biliary insufficiency.

**Administration**—One to two tablets twice daily after meals.

---

## FALGOS

**Manufacturer**—Carter, Cummings & Co., Ltd., Windsor.

**Description**—Analgesic-antacid, buffered to prevent stomach irritation. Each tablet contains: Acetylsalicylic acid  $3\frac{1}{2}$  gr., phenacetin 3 gr., caffeine  $\frac{1}{2}$  gr., aluminum hydroxide, magnesium hydroxide.

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# 1956 INDEX

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## *L'Infirmière Canadienne*

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**MONTREAL, DECEMBER, 1956**

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### Christmas in Korea

AS WE SAT, the lamps were put out and we saw again the beauty and the magic of the Nativity scene. In the soft candlelight sat Mary with the Babe in her arms, gently rocking to and fro. There was little sound excepting the restless movement of the animals that were near her until, through the door, entered first one then another — with splendor and dignity, the three Wise Men came bearing their gifts of gold, incense and myrrh. As each knelt to leave his gift at the feet of this Mother and Child, we felt again the wonder of the ancient story, reenacted in a hospital in Korea. We who watched grew rich in this inheritance of Christmas. Then Joseph rose from behind Mary and lifted up his hands in prayer over the bowed heads before him. His blessing was received with deep humility and a new understanding.

It was only when the lamps were lit again that I recognized that all the heads around me were black — that I alone was fair; that the prayer had been given by a child in the Korean language that I had failed to master in the months I had been in this strange land far from my own home; that those around me were young in heart and age — war orphans from

a United Nations war — while I was old from my own struggles and the weight of their tragedy. From the side lines came the Korean nurses, confident in the new found knowledge and the resources given to them by the many from the free nations who had reached out a helping hand. These young nurses had made the tableau possible knowing the need of the children who, missing the love of their parents, must find another love — even if the gowns of the well known characters were relief blankets and towels, the incense container a broken toy. How I smiled to myself when I finally discovered that one "gift" was a mechanical toy that once had played "Four and twenty blackbirds baked in a pie," as the little blackbirds bobbed their hands through holes in a tin plate; that the restive "animals" had mischievous oriental faces under the army blankets!

The Korean nurses knew that before the children's cup of happiness would be full there must be gaiety and laughter. So in they came carrying great baskets of apples, a gift from the adult guests who had come to share the Christmas Eve with the children.

Soon the youngsters were all tucked



*Gold, and Frankincense and Myrrh*

into their beds as was essential in the regime of treatment for tuberculosis. The sanatorium itself had been a tangible gift of friendship from Canadian children who, through the pennies and nickles and dimes donated to the Junior Red Cross, had raised the amazing sum of \$87,000 in two and a half years.

Christmas Day was spent in the atmosphere and surroundings of an army compound. There the children revelled in the gifts from absent relatives or friends who had stretched their meager incomes to the limit that something might be sent. Towards evening, I joined Canadian friends at the mission house. We talked of home — that wonderful land we all loved so much, Canada. We exchanged simple gifts from our own boxes that marvellously had produced enough to provide a laden and festive table, reminiscent of Christmas dinners at home. Afterwards, we sang the old, familiar Christmas carols until the day was done.

As we rose to return to our various billets we knew that on the morrow we must continue to face and try to

do something about the great tragedies of this land, Korea. The kindly leader of this band of Canadian missionaries stepped forward and, raising his hands, blessed us, asking that strength be given to each of us to meet our tasks in the days to come.

As I stood there I knew I had learned the true meaning of Christmas the night before from the little children. There they were — children with coal black hair and slanted eyes; children who had lost their loved ones; children who were poor and ill with tuberculosis but who now were rich because they could have good nursing care. What if the care they received was being given by young, inexperienced nurses who were learning the meaning of care under indescribable hardships? Somehow, these new nurses had made it possible for those children to celebrate Christmas so that I, too, caught a glimpse of a basic truth. Good nursing is a mighty weapon in the world's struggle for "Peace on earth, goodwill toward men."

HELEN G. McARTHUR

## Happy Christmas, Everyone



# A Pediatric Work Conference

MADELEINE FLANDER

## INTRODUCTION

AT SOME TIME during the two or three years when a young woman is learning to care for the sick, she is likely to be taken abruptly from her familiar moorings, the adult wards in a general hospital, and moved to what must seem like a turbulent sea, the children's ward or the children's hospital. To many who are working with students in pediatric nursing, their reactions are interesting and in some instances cause concern. In the wards, there may be differences in emphasis in the care, the children may seem to have a great deal of freedom or parents may have many more privileges in visiting. Because of the children, the staff may seem more closely involved with the patients, their parents and each other. The whole atmosphere, in spite of the presence of acutely ill patients and the familiar equipment for their care and treatment, can be quite different.

The staff of the Montreal Children's Hospital became interested in the reactions and needs of affiliating student nurses. They decided to hold a conference and to invite to it the directors

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Miss Flander is Director of Nursing Education of the Montreal Children's Hospital.

of nursing and of nursing education of the schools sending students for affiliation.

The general plan of the conference consisted of five short talks about the pediatric setting as seen by the doctor, the child, the parents, and the psychiatrist. These talks were followed by discussion, in small groups, upon four broad topics. It was thought that the talks and the selected topics would help to give direction to the discussions. The topics were related to the responsibilities of the nurse in the pediatric setting, concepts of the "ideal" nurse which the student nurse brings, reactions which the student may show as she understands her role, and areas for combined effort between the home and affiliating schools.

In relation to this "cooperation," it is difficult, perhaps, to see how the pediatric experience can be related to the whole progress of the student nurse with relationships to that which has preceded it and to that which will follow. The label of "specialty" and "specialized school" is widely used and planning together is probably not widely practised.

The material which follows consists of a description of the process of the conference, the addresses which were given and the conclusions which were brought from the discussion groups.

## Process Notes on the Work Conference

HEDLEY G. DIMOCK, M.A. Ed.D.

THE PROCESS OF A WORK CONFERENCE, such as the one described in some detail in this issue, is an important

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Dr. Dimock, the director of group guidance at the Montreal Children's Hospital was previously on the staff of the Center for Improving Group Procedures, Columbia University, New York.

dimension to consider in reconstructing the conference. Process can be best defined as the way in which things are done. How the conference is planned, how the members participate, and how they interact with one another and the conference staff are all vital questions in a consideration of process.

The work conference was organized

by Miss Flander. It had been five years since the hospitals affiliating with the Children's had all met. Another meeting of this group was long overdue and Miss Flander felt that a work conference might be more beneficial to all than the usual series of meetings.

The objectives of this work conference were to:

1. Increase the understanding about the student nurse in her pediatric training.
2. Envisage more clearly the role of the pediatric nurse and the pediatric hospital in the community.
3. Define possible areas of cooperation between the student's home hospital and the pediatric hospital where she affiliates.
4. Facilitate an understanding and warm relationship between the Montreal Children's Hospital and the home hospitals, as well as among the home hospitals themselves.

It can be seen that achieving these four objectives depends to some extent on the way the conference is conducted and the structure within which people interact with one another. This is process and it is an integral aspect of a teaching-learning situation.

The role of process in conferences, classroom teaching, group meetings and other forms of interpersonal relations is becoming increasingly recognized and planned for in operation. What is done and how it is done go hand in hand, each depending on the other for the ultimate success of the whole. The relatively new field which explores group phenomena and how things are done in groups is called group dynamics or group psychology.

#### PARTICIPANTS

The population of work conference participants was composed of directors of nursing and of nursing education from hospitals affiliating with the Children's. In most cases both people came as the representatives of their hospital. Representatives of the Quebec, Ontario, New Brunswick, and Prince Edward Island Nurses' Associations were also present.

#### PLAN FOR PROCESS

The process of the conference was

planned to help meet the specific objectives of the conference. The first objective of increasing the understanding of the student nurse in her pediatric training was planned as a series of short talks by representative members of the Children's staff. It was felt that such talks would give different perceptions of the role of the pediatric student nurse. The talks were also expected to give a structured orientation to the content of the work conference. The last three objectives were planned for through a series of informal group discussions or work groups. These groups, it was hoped, would help the members clarify and crystalize their own thinking; and also enable them to meet people in similar jobs from other hospitals. Two informal luncheons were planned which were expected to facilitate the interaction of the conference members.

#### CONFERENCE IN ACTION

The conference opened with the welcoming of the members to the hospital and the conference. Several brief talks by representative members of the hospital staff followed. (The content of these talks is recorded in following pages of this issue). After the talks there was a brief question period.

The afternoon session started with the first period for work groups. These groups were organized so that no two people from the same hospital were together. Each group had a leader, a staff member from the hospital, and a recorder, who was selected from the group. There were five groups, each with about eight members. All groups discussed the same general topic — "What are the responsibilities of the nurse in the care of children?" The topic was designed to be broad enough to allow scope and flexibility in the discussions. A definite topic was assigned, however, to give some structure and direction to the conference. The topic for the following morning were: "The concepts of the ideal nurse which the student brings to the pediatric setting" and "The reactions that may occur as the student comes to understand the requirements of the pediatric setting." The topic for the third and last group discussion period was "How can the general nursing

experience and the pediatric nursing experience help the student to become happy and effective in nursing?"

#### LEADERS AND RECORDERS

The work group leaders were selected from the staff of the Montreal Children's Hospital. The leaders were not all from the nursing staff as they were selected for their ability to facilitate group processes rather than for their knowledge of pediatric nursing.

The leaders met before the conference and received an outline of what their function would be. The role of the group leader could be summarized as follows. The leader:

1. Helps the group to get acquainted.
2. Reports on preconference planning for the work groups.
3. Helps the group define and focus on the problem.
4. Assists the recorder and calls on her, from time to time, for summary.
5. Draws out the quiet person and keeps the dominant person from monopolizing the discussion.
6. Helps all points of view to be expressed.
7. Keeps the discussion focussed on the problem.
8. Points out the progress of the group and highlights its success.
9. Helps the group move from the abstract and the theoretical to the practical which is action orientated (something the group can do something about).

Toward the end of each session the leader called on the recorder to give a summary. Then the leader and the group helped the recorder to work up the summary for a report to the total group. This was used as closure for each work group session.

The recorders came from within the work groups and usually volunteered for the job. Different people usually took the tasks of recorder at each of the three sessions as this task severely limits person's participation. Job descriptions for the recorders were drawn up before the conference. These were passed out to the recorders at the conference. The function of the recorder was pointed out to be quite different from that of a stenographer. The recorder was described as a sort of creative listener. She was to record

the main points made by the group, organize them for use by the group, and prepare them, with the group, for presentation to the whole work conference.

It was suggested that the recorder keep track of:

1. Points on which members agree.
2. Points on which there are differences of opinion.
3. Points on which she is not sure how the members feel.
4. Points mentioned but not fully discussed which the group may want to come back to later.

The recorder was instructed to seek additions and corrections to the report as it was supposed to represent the thinking of the whole group. The recorder, with the group, was expected to decide what parts of the report would be related to the whole group at the general session.

#### FEEDBACK

Feedback is the process by which the individual groups share their work with the other groups which constitute the conference as a whole. At this conference three different methods of feedback were used — one at the conclusion of each of the three work group sessions. The first one is often referred to as the *group interview method*. The conference leader asks for one point or conclusion from any one of the recorders. He lists this on a blackboard or newsprint and asks if any other groups discussed this same point. He interviews each group that discussed this point and collects their ideas. Other ideas may be added from the floor. This procedure is carried on through all the major points of each of the discussion groups. Its chief advantage is that it avoids duplication of points and concludes each point before going to the next one.

The second feedback method used was *straight reporting* from each group recorder. Each recorder reviewed all the points made by her group. Again, these were listed visually so that all could follow them. This procedure allowed the recorders to demonstrate the total thinking of the group in its logical sequence.

A *panel discussion* among the recorders was the third method used.



The recorders sat together facing the group while points were listed on a board at the side of them. Contributions were discussed by all the recorders as they were brought up. At the conclusion of their discussion the meeting was thrown open to reactions by any of the participants. This method, which incidentally was preferred by the recorders, eliminated the repetition of points and still allowed for some logical development of each group's thinking. It also helped the recorder to feel more at ease. During all these feedback sessions the conference leader attempted to clarify and focus the ideas and get all points of view expressed. The record of each feedback session was mimeographed and given to the participants before the next work session.

### EVALUATION AND CLOSURE

In an attempt to analyze and evaluate the conference both in terms of what the participants felt they got out of it and the process used, a brief questionnaire was filled out by the participants at the last session. Here is a summary of the questionnaire, 32 participants responding.

I. On the whole I felt this conference was:

(check one)

18 — excellent

14 — good

0 — so-so

0 — poor

0 — useless

II. I felt the most successful part of the conference was:

11 — the discussion of our common problems

4 — summaries of work groups at the general feedback session

2 — the talk on the student nurse

1 — good relationship among staff at Children's hospital, all working together to make the conference successful

1 — learning how to prepare students for their pediatric affiliation

III. The most important thing I got out of the conference was:

9 — the ideas of others towards affiliates and affiliation

3 — understanding the problems in pediatric nursing

2 — the necessity of discussing problems frequently and working on them together

1 — learning newer concepts in working with children

1 — stimulation to improve patient care and student satisfaction

1 — observation of free discussion in work groups

IV. The conference might have been improved if:

13 — more time was available

3 — students had participated

2 — topics for work groups had been more clearly defined

1 — there had been more discussion from the floor

1 — more directors of nursing had been present

V. Do you feel that using the work group method was successful?

31 — yes

0 — no

Did you like this method?

31 — yes

0 — no

VI. Would you be interested in a future conference of this type?

31 — yes

0 — no

### RELATED READINGS

Benne, Kenneth and Bozidar, Muntyan. *Human Relations in Curriculum Change*. New York: Dryden, 1951.

Maier, Norman R. F. *Principles of Human Relations*. New York: Wiley, 1952.

*Adult Leadership*. Vol. I No. 10 (March, 1953); Vol. II No. 1 (May, 1953); Vol. II No. 2 (June, 1953); Vol. IV No. 7 (January, 1955).

The wealth we may accumulate, the public prestige we may enjoy, the social position we may obtain, are all meaningless in the long vista of time, unless all are made to serve the cause of human dignity and free-

dom. What value dollars, or acclaim, or position in a world where justice, opportunity, and freedom are lost to us by force, by subversion, or by our own neglect?

— DWIGHT D. EISENHOWER

# The Pediatric Setting

ALAN ROSS, M.D.

IT IS IMPRESSIVE, INDEED, that so many from different schools and branches of the nursing field should come to talk over together problems of common interest. We are very proud of our nursing service, and have worked diligently with the nursing staff in evolving sound attitudes aimed to meet the needs of our young patients and also the needs of the undergraduate nurse.

Looking at the pediatric setting, in which we find ourselves working, from the point of view of the medical practitioner I am impressed with the fluidity of the whole scene. I feel that we are all trying harder than we did in the good old days when things were more settled; trying harder to adapt ourselves and our teaching to present needs.

There has been a dramatic change in the diseases from which our patients suffer. As the result of public health activities, immunizing campaigns and nutritional education, such conditions as typhoid fever, diphtheria and rickets are only rarely seen. Most children with pneumonia are either treated in the outpatient department or are in hospital only a few days. Infants with meningitis, even tuberculous meningitis, now recover. Diarrhea and vomiting in infancy is no longer the annual scourge that many remember so well.

Children are recovering quickly and, in most cases, completely from their acute illnesses. Unfortunately, this cannot be said for the chronic diseases, and many beds are still filled with those suffering from rheumatic fever, nephritis, congenital abnormalities and neoplasms.

A change, too, has taken place in the parents. They are still the same parents ready, in most instances, to sacrifice to the limit for their sick

children. But they no longer have to accept an unpronounceable diagnosis and hope that all will turn out well in the end. Now they have many sources of information and, unhappily, misinformation. Some of this new knowledge is extremely helpful, and has made the care of the sick child much easier. Some of it has complicated the picture. In any case, this partly informed parent must be met with patience and understanding. What *Time* and the *Reader's Digest* have to say must be worked into the fabric that we are weaving around his child's illness.

The type of illness, then, is changing. Parents are expecting more than witchcraft from their doctors and nurses. However, I cannot but feel that the greatest change is taking place in ourselves and in our own attitudes. In the first place, we have come to realize that a child with cerebral palsy, for example, cannot be adequately treated by one person. The physician must be in charge but the physiotherapist, the occupational therapist, the social worker, the psychologist and the play therapist almost always have contributions to make towards good recovery. This fact has resulted in the formation of teams to study and help in a number of special illnesses of this kind. Through such a combined approach, and stimulated by our Department of Psychiatry, we are learning, too, that an illness has implications for others than the patient. It reaches out and involves indirectly the home, the patient's friends, the school, and in many instances the whole community in which he lives.

Our attitudes, then, towards a sick child, are broadening. Great changes are taking place in the problems that confront us. It is heartening to find you are aware of this changing pediatric setting, and ready to face these new problems in the nursing care of infants and children.

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Dr. Ross is Physician-in-Chief of the Montreal Children's Hospital.

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*Comment on conferences:* God needed only six days to create the world, but He had the advantage of working alone.

# The Child in Hospital

JEANNE E. FAUGHNAN

THE CHILD COMING INTO HOSPITAL brings with him not only his physical and medical needs but all of his other human needs as well. His ever-demanding emotional, social and creative needs are as much a part of him here as elsewhere. To neglect trying to understand and taking steps to meet these needs may result in returning the child to his home more ill in a real though different sense than he was when he came to the hospital. Before considering how illness and hospitalization may effect the child let us look at some of the basic capabilities of children in general so that we may be better able to appreciate what these major experiences can mean to them.

The nature of a child's perceptions, the quality of his relationships, the pattern and intensity of his needs and the variety of the sources of their satisfaction differ from year to year as the child grows to adulthood. This becomes evident when we consider the varying quality of the relationship the child has with his family and friends as he grows up.

In infancy the mother is all important and the child enjoys a large measure of dependency. As he grows older he turn to his peers for support in taking on responsibilities independent of his parents. By the time the child has reached the nine to twelve-year period of his development he is experiencing a great need to be accepted by a gang of children of his own age and sex. Exclusion from it would be most distressing for him. He must feel that he is like his friends in every way to reassure himself that he is a worthy and capable human being.

The support the child gains from the knowledge that he has many close friends continues to be a need in the adolescent period of his development. Now, however, heterosexual relationships, physical appearance and popularity for its own sake become vitally

important. The child at each period of his development must feel that he is achieving its goals if he is to be free from anxiety and be willing to assume the more mature attitudes and goals of the succeeding stage.

Another basic property of children, which we must understand if we are to appreciate the meaning of their experiences for them, is that they are subjective human beings. Along with their dependency goes their egocentricity causing them to perceive the happenings of their life in a subjective manner. People, things, situations may go either completely unnoticed or be greatly exaggerated depending on how the child feels about them. Thus, he sees things not as they are but according to how he feels about them.

The child has little factual knowledge against which to test his impressions. Every day strange and unexpected happenings occur as he is exposed to new experiences in the world. He cannot tell the real from the unreal. His own imaginings and the "tall tales" of others are seen as the probable since so many fantastic things apparently do occur. It is particularly difficult for a child to understand illness. His "magical" thinking and lack of knowledge of its causes and effects may be sources of great misunderstanding to him as to its true nature.

All children coming into hospital must go through a process of adjustment to the factor of illness and the experience of hospitalization with all that it implies in terms of separation from family and friends, adjustment to strange and often unpleasant procedures, the forming of new relationships and other happenings. One can make no generalizations about how a child will adjust to this event. The same situations will have different meanings for different children. The child will meet the experiences of illness and hospitalization and deal with them in terms of the strengths and weaknesses he has developed through his previous life experiences.

The child on being hospitalized be-

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comes separated from his parents at a time when he needs them most. Good or bad they represent the only security he knows. His primary concern in his childhood is to be sure that they love him. He may interpret separation from them as desertion by them. This may cause him to feel that they do not think him worthy of their love which will consequently damage his feelings of personal worth. Sometimes children interpret hospitalization and illness as forms of punishment inflicted on them by the parents, especially when they have been made to feel guilty by the parents for past "mistakes."

Since the mother-child relationship is primary, especially in the early years of life, every effort should be made by the hospital staff to foster the maintenance of a close tie between the child and his home. At the same time, within the hospital, children must have a warm personal relationship with the person caring for them to feel secure. The adult responsible for their well-being must establish this relationship by offering them the love and recognition they need.

Hospitalization for the very young child or an illness that is of long-term duration for the older child can seriously impair the child's future ability to form interpersonal relationships. When the child relates to other persons he does so on a very personal level. A break in this "friendship" by the adult may be difficult for the child to understand. He may interpret it as implying a rejection of himself as a person which may cause him doubts about his own worth. It may also cause him to have serious doubts as to the trustworthiness of people in general. Should he be let down by adults in this way with any frequency he will begin to withdraw his love from such relationships and enter into them on a superficial level for the more obvious gifts and favors they can bring to him. This pattern for forming relationships may then become a basic personality trait of the child and interfere permanently with his ability to form stable and mutually satisfying friendships with other persons.

Illness and hospitalization can cause even well adjusted children to feel strange and fearful. The child may

react to it by becoming outwardly aggressive in his behavior, apparently independent and able to manage his own affairs or, he may become more dependent, turn his feelings in to himself and become more anxious. It is well to remind ourselves that while the former means of expression is more apt to disturb the smooth functioning of hospital affairs the child is finding expression for his feelings and is overtly letting us know of his need for help. The latter form of expression is more apt to go unnoticed and we may not recognize the child's need for help until his anxiety overwhelms him.

The feelings children have are spontaneous. Only the form of their expression can, to some extent, be controlled. Their direct expression, either verbally or through behavior, is the most satisfactory method of releasing the tensions they create in the child. If the child feels that for some reason their expression would turn people against him he will try to suppress them which will only serve to increase his tension and eventually he will be forced to find some release for them sometimes in camouflaged or bizarre forms of behavior. A child will know that we do understand and love him when we let him know that we accept his feelings as being natural whether they be angry or friendly. We can also help him to find ways of expressing these feelings. At times he can be helped to express them verbally; at other times he will need to act them out. Adults can help the child to find socially acceptable outlets for these feelings thus providing him with tools to use for similar future experiences. However, unless the tools we offer the child provide an adequate medium for the intensity and quality of his feelings they will not provide an appropriate outlet for them.

There are many things we can do to help the child to cope with a stay in the hospital. We can make illness less of a mystery to him by giving him as many facts about it as he can understand at his age and so help him to separate the real from the unreal. If we are honest with him at all times he will learn that he can trust us. We can prepare him for each new experience so that he will know what to expect. If he believes that we will

always do this he won't have to sit in bed conjuring up horrible ideas of what we might spring on him next. We can be with the child during his trying experiences. If he already trusts us his fear will be lessened and he will be more able to endure the pain in treatment.

The child in hospital must find opportunities for self-expression and for meeting his needs. He does this on an overt level through his behavior. The major part of this behavior takes the form of what adults call play. It provides one of the most satisfactory channels for the child to express his real feelings, whatever their nature, since adults will accept many activities as play which they cannot accept when acted out in a real life situation. Thus, such truly direct expressions as kicking or biting a person, inflicting pain or expressions of anger against the restraining hospital by upsetting meal trays would not be encouraged forms of behavior but at the same time the feeling that prompts them can be recognized and accepted, and alternate forms of behavior proposed. Play activities will often serve as acceptable, alternate vehicles for such feelings and release pent-up emotions.

It is through what we call play that the child meets many of his emotional, social, intellectual-creative and physical needs. Play activities provide the tools he understands best for establishing relationships with other people. In play he investigates what things, people and situations are like and experiments in using himself in relation to them. Since play, if it really is to be play for him, is of his own making, or that of his peers or with an adult who understands him, it is always at his level of understanding and he can function in it. Thus play encourages his feelings of self-confidence and adequacy and stimulates him to think and act independently. Such thinking and acting are always to be encouraged if the child is to grow up to be a mature adult. This is particularly true in a hospital which by its very nature tends to promote feelings of dependency and regression in the child.

In his play the child re-enacts his previous life experiences at his own level of understanding. Sometimes these are pleasant happenings and he

experiences again the happy feelings he had at the time of their occurrence. Sometimes they represent what the child wishes would happen and he experiences almost as much pleasure in them as though they had. At other times they are a review of unpleasant past experiences and in re-enacting them the child sifts and sorts the various components of the event and comes to have a clearer and more realistic understanding of them. He can then try out new ways of behaving himself in relation to such situations in the light of the new insights he has gained by this review of former happenings.

Too frequently it happens that adults arrange hospitals to suit their operational needs and their own standards and values. Thus, hospitals are apt to be very clean and orderly, efficiency in routines may be a major goal, quiet and "good" children may be desired. But a child-serving hospital must be a child-centred hospital. Priority must be given to providing an environment in which the child's interests are best served.

When the child trusts the people looking after him and feels secure in his environment his major concern becomes that of working towards the goals and objectives of the world which he left on coming to the hospital. He shares the standards and values of either his family or his peer group. Hospitalization and illness are seen as threatening to him as he imagines they will interfere with his place in his own world. They are seen as especially threatening to him as they affect his ability to return as an active participant to this world.

The child in hospital, certainly in the primary stages of his illness, will want to be babied and a certain amount of this will help him to feel more secure. He will test the dependability of the adults in many ways sometimes by calling them many times to see if they really care about him and if they really will come when he needs them.

However, he will soon need to have opportunities for independent thought and action, which are major necessities of healthy human beings. Let us see to it that there is a minimum of rigid rules and routines restricting the child. Let us find opportunities for children to contribute their thinking and plan-



ning for their own affairs for, while the obvious results might be the same if we do all of the planning, the child thrives on the experiences of assuming responsibility for his own behavior. Within

the basic essential safety limits let us offer decision-making experiences for these children whether they revolve around group living affairs or what we refer to as the children's play.

## The Student Nurse in a Pediatric Setting

HYMAN CAPLAN, M. D. and HEDLEY G. DIMOCK, M. A., ED. D.

**M**ODERN ELECTRONICS could probably invent a machine that would dispense medications, chart temperatures and make beds more efficiently than nurses. Though such a robot could do many things it could not begin to be a good nurse in terms of taking care of all the needs of the patient. Even a "poor" nurse establishes some relationship with the patient and makes some contribution to his emotional and social needs. Modern nursing is essentially a human interpersonal relationship. The emphasis is on the *interpersonal*. The techniques, duties, and routines are merely the vehicles of this interpersonal contact.

Let us examine some of the varied aspects of the interpersonal relations of the student nurse in the pediatric ward in order to get a more accurate picture of her role and problems.

Nursing children is often more challenging and difficult than nursing adults. Close contact with a child for any length of time brings out the personality strengths and weaknesses inherent but often camouflaged in adult relationships. The nurse sees the child and his family under crucial situations and the interplay frequently reveals problems that may be related to her own childhood or her own family. These feelings may not be lightly dismissed, but must be understood and dealt with appropriately.

These most basic attitudes on the part of the nurse set the atmosphere for the hospital ward. The ward cli-

mate is a very important factor in the treatment of a sick child. The child senses this climate and responds to it. The parent, too, is influenced by this ward atmosphere and the security it emanates will be of marked importance in allaying the mother's fears over hospitalization, separation and so forth, and may make her less demanding and troublesome to the nurses and doctors.

A student nurse coming into a pediatric ward for the first time is faced with the following problems:

1. Learning relevant information:
  - a. Facts, routine, skills and so forth, relating to the physical conditions of the patients.
  - b. Information regarding the emotional and social needs and development of children.
2. The interpersonal process:
  - a. Relationship with the doctor in charge.
  - b. Relationships to the head nurse, supervisors, instructors, and other staff.
  - c. Relationships to other student nurses.
  - d. Relationships with the patients and their families.

We will attempt to touch only on basic information regarding personality growth and development and the interpersonal process.

One approach to understanding personality can be termed the "developmental need" theory. It sees children striving to meet certain needs. The first need of the child is to develop a sense of *trust*. This trust is usually found in the warm relationship with the mother. After this security has been found and the child feels he can depend on it, he attempts to es-

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establish his independence as an individual. This is a need for a sense of *autonomy*. Around four years of age children strive to accomplish things and to be creative. They want to get out into the world and see what they can do. These children are said to be developing a sense of *initiative*. When children are unable to satisfy these needs they will continue to seek their satisfaction into adult life. The satisfaction of these needs — trust, autonomy and initiative — are a prerequisite to a healthy personality.

Healthy personality can also be viewed as a kind of dynamic equilibrium state in which many forces are delicately balanced. These forces are complicated and to some extent inadequately explored. Basically, in good health, there is a delicate relationship between the various components of personality, the id, the ego and super ego, and the environment.

At this point we do not wish to elaborate on the development of personality but merely to discuss the significance of the emotional climate in which the child is reared. The more the nurse knows about the child's physiology, anatomy and illness the better she can serve his physical needs. Similarly, the more she understands the child's emotional and social background, the better she can deal with his adjustment to the hospital, his sickness and his personality disturbances.

We will now discuss three types of backgrounds which in their extremes are unhealthy for the growing child.

#### MATERNAL DEPRIVATION

Human beings cannot develop in a vacuum. The infant is born into the world helpless and entirely dependent on others for survival. The early relationship with the mother is essential for survival. Gradually, however, the infant moves on to an identification process that not only gives him food and warmth but also a concept of right and wrong. Thus, the beginnings of character structure and personality develop. This opportunity to introject and identify with a person in one-to-one continuous relationship is very important. Where it is absent we see

serious disturbances in children. For this reason, it is preferable to place parentless infants in foster homes rather than in institutions. The infant needs a continuous human relationship. Too many people looking after him confuse him. He can't begin to know, trust and feel secure with any of them. For the same reason infants should not remain hospitalized for too long. This is why the nurse dealing with the infant should try to give him a great deal of human contact and social stimulation. Nothing has shown the integration of psychiatric principles more than the day when four nurses attended ward rounds each carrying and cuddling a small infant in her arms, and this was viewed as natural by the staff.

We have all seen grossly deprived children come into hospital. It is very gratifying to see how they improve in response to adequate nursing and human stimulation. Maternal deprivation in infancy may lead to listless, apathetic and unimaginative children who may develop shallow, incomplete personalities in later life.

#### MATERNAL REJECTION

Mothers, for many reasons, may reject their children. Children who are rejected find it very difficult to develop the first prerequisite of a healthy personality — a sense of trust. Manifest rejection of children in our society is not socially approved. Dislike and resentment of children is usually hidden very skillfully. Frequently, a mother is not aware that she really rejects her children. Rejection may take the form of overprotection. The overprotective mother appears to bend over backwards to take care of the child and give him everything he needs. This outward behavior may be a compensation for her real emotions. Such mothers often sacrifice a great deal to prove to the world that they are "extra special." Basically, they want to convince themselves that their negative feelings towards the child do not exist. The nurse must be very sensitive to meet the needs of the rejected child. Usually in cases of total neglect the doctor will bring in the trained social worker, and, if necessary, the juvenile court.

Maternal overprotection is a form that unconscious rejection often takes. It is usually related to guilty feelings on the part of the mother. This is an emotional climate frequently seen and also one to which nurses often react poorly. "He is spoilt" may describe the situation accurately but the usual attitude that accompanies this remark is not conducive to good nursing. The "spoilt" child is as unhappy and disturbed as the obviously deprived or rejected child. The nurse here is likely to get involved with the parents, too. The proper handling of such parents requires a great deal of skill if it is to be geared to the total needs of the hospitalized child.

We have already indicated that rejection may be camouflaged by overprotection to be socially acceptable. Overprotection is usually of two sorts:

1. The domineering, controlling, stifling kind of mother-child relationship where the child is never allowed to grow up and have a mind of his own.
2. The over-indulgent permissive mother-child relationship where the child is in constant control of his mother and the home. Here the child has never been allowed to experience any reality controls or limits.

The good nurse realizes how difficult it may be for the first child to have enough courage to *make* requests and how equally difficult it may be for the latter to *stop making* demands. Further, a nurse is prone to react to these situations not as if she were a partner in a healing team but rather as if she were the child's mother. More difficult situations may arise where the nurse over-identifies with the child and relives feelings reminiscent of her own childhood.

## PLAY

Play is another important medium through which children grow and develop. The nurse should have some clear information regarding its importance. In play the child exercises his muscles and increases his coordination. Here children meet and learn about other children. They also develop their ability to get along with each other and to cooperate on joint projects.

Play provides the education for the young child. In this way he learns about the world around him and the people who live in it. Play provides, too, for emotional expression and is a natural outlet for feelings of hostility and aggression. Much of a child's personality and "self" concept is developed through play and its simple forms of role taking. Play provides an opportunity for children to learn how others feel about them. It also opens opportunities to develop skill in shifting from one role or type of behavior to another.

Thus it is that *planned* and *unplanned* play activities are part of the life of the child and therefore should be part of the life of the children's ward in a hospital. One may have to modify certain types of play to meet the needs of special disabilities of sick children but one should not curb it. Children cannot be expected to lie in bed like mummies even if a doctor thinks it is good for them.

## INTERPERSONAL RELATIONS

Two of the most important influences on the emotional and social well-being of children in the hospital are their relationships with the nurses, and the nurses' relationships with each other and the rest of the staff. The latter is important because the interpersonal relations of the staff determine the amount of teamwork or coordination of work on behalf of the child patient. Recent studies also suggest that problems among staff are played out in the relationships with patients and distort these relationships. Certainly, a staff that gets along well together is going to be happier and more at ease.

The relationship of the child with the nurse is determined as much by the feelings and attitude of the nurse as by the child. A nurse with a confident, healthy self concept, one who understands herself, is most likely to develop relationships with higher potentialities. The childhood experience of the nurse often comes out in her relationships with other children. Student nurses — being in their late teens — are often upset by children in their early teens who are facing some of the same problems of adolescence that



they themselves have not yet fully worked out. A child may touch off tension in a nurse by behavior reminiscent of her own life experiences.

Being a "student" nurse makes these relationships all the more complicated and difficult. First, the student is not yet a nurse but must carry out many of the duties of the regular nurse. The student is usually aware of this although her patients are not. Second, the nurse, and especially the student, is at the bottom of the hospital's hierarchy. Hospital staffs are very aware of this. A great deal of the normal procedures within the hospital framework and the student nurse program perpetually reinforce this hierarchy. In a general adult hospital she may have to follow out orders of the adult patients and it is questionable who has more authority — the older adult patient or the young student nurse. In the case of children the student feels she should be in the authoritative position — often the reverse of her relationship with a mature adult patient. She may take advantage of this authority and *boss* the children to raise her own self-esteem. Again, the student nurse is somewhat isolated in the community as well as in the hospital.

Nursing, in the interpersonal sense we have been describing — is not significantly appreciated by the average physician. The doctor only too often is more concerned with the efficiency with which his orders are carried out than with the spirit in which they are made available to the sickly child.

Parents of children constitute another group with whom the student nurse is likely to have difficult relations. They represent a challenge and a threat to many students. When the parents are present they are more important to the child and the nurse's ego may suffer. The parents, too, seem to represent a higher authority than the nurse and this may challenge her — as if to say: "Well now, what kind of a job have you been doing with our child?" The student is a threat to the parents in the same way and this increases the likelihood of difficulty in the nurse-parent relationship.

The student nurse usually does not receive the guidance and supervision that is given to late adolescents in other

areas of professional training. In college, for instance, these girls would find a great deal of help available in the form of big sisters, faculty advisers, guidance counsellors and deans of women. Many hospitals give their students adult responsibilities on the one hand and yet treat them as children in their private affairs. The student nurse needs an atmosphere of warm acceptance with her supervisors as well as an opportunity to talk over her work, her patients and her problems. At times short talks and a closer personal contact with the senior instructors will suffice. At other times group discussions under competent leadership are indicated and even, occasionally, special counselling is necessary for the student as well as for the staff nurse dealing directly with the student nurse.

The question might be raised as to how well the schools of nursing are meeting the responsibilities of making the student aware of these basic areas of functioning. It would seem that many schools are too concerned with temperature and pulse charts, trim beds neatly arranged in rows, and a rigid atmosphere of discipline, propriety and authority organized in a hierarchy from the director of nursing down.

Understanding the total needs of a patient is more than learning skills and facts. It means the acquisition of a basic understanding of personality in general and one's own personality in particular. A major goal for nursing schools in addition to supplying basic knowledge should be the growth and development of the student nurse into a mature personality in order to contribute more fully to the clinical healing team of a modern hospital ward.

Thus it is that the learning experiences of the student nurse are rather unique. The many difficulties that are inherent suggest a need for greater understanding of their responsibilities and of each individual student's reactions. Further provisions within the hospital for helping the student nurse develop appropriate and satisfying interpersonal relationships especially in the ward setting are mandatory. And last but not least a plea is made for the physician to develop a keener awareness of all the intricacies involved in pediatric nursing beyond the physical ministrations to the sick patient.



# The Parents' Point of View

CHRISTINA F. JAMES

**W**E HAVE BEEN looking at the pediatric setting from the viewpoint of the doctor and from the viewpoint of the child. How does it appear to the parent? As illness is no respecter of persons or classes, any parents may be affected by the hospitalization of their child. In our society the hospital caters to rich and poor, the educated and the uneducated. There will be parents who have had a good deal of experience with hospitals and those who have had none. There will be Canadians with a good understanding of the whole community, including the hospital, and there will be foreigners to whom everything is strange. In the latter group there will be people from other lands where hospitals are only for the dying or the indigent. There will be parents who speak other languages and who cannot communicate with the staff with any degree of satisfaction to themselves or to the hospital personnel. There will be parents who are extremely poor and have been deprived in every direction, in turn being unable to give their children what they want to give. To these people the hospitalization of their child is just one more blow. There will be parents who have every material possession and some who think that money can buy anything, even health. To any of these parents the hospitalization of their child will present some problem.

The inclusion of the parent viewpoint in these discussions is a recognition of the fact that hospital staffs tend to concentrate on the patient and to forget the rest of the family. In the pediatric setting, we forget that the child is part of the family group and that what affects the rest of the group will affect him even though he is away from them and in hospital. How he gets along when separated from them is dependent not only on the well-being and the attitude of the

family at the time, but what has gone on before. The parents' attitude towards hospitals in general and towards the child's admission in particular will condition the child towards this procedure.

Probably the most important factor influencing the parents in their attitudes is their ignorance of procedures. How can they prepare their child for hospital when they do not know what to expect themselves? It is true that this does not occur to some parents at all, but nowadays many know that children should be prepared and would like to do it, if they were able. Even a well-educated parent may be ignorant in this respect, and the better educated he is, the more diffident he may be to show his ignorance or to appear to ask silly questions. This has led to quite unnecessary pain for the parents and for the children. Procedures which seem quite simple to those of us who work in a hospital are terrifying to the uninitiated. In this class are the various tests such as an encephalogram or those which require the insertion of a needle into a vein. Very often parents, instead of asking questions, will go away and discuss them with other members of the family or friends who are equally ignorant. They may build up an increasing fear about what is happening to their child in hospital.

Another type of parent, the one who is not very well-educated and possibly has led a deprived life, or the one who has come from another country and does not know what is normal and what is not normal in this country, will not ask questions because he feels he has no right to the information. He looks at the large institution with awe and respect. It seems to him extremely complicated, as we will admit it is. The doctor appears as an authoritative god and the nurse as a very efficient person, far above them. The parents feel inferior and know that they cannot compete with these efficient people in the care of their child. They may also have a

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Mrs. James is director, Social Service Department, Montreal Children's Hospital.

feeling of failure or that they are to blame for the condition which has necessitated the hospitalization.

These feelings of inferiority and guilt will be very much increased if any member of the hospital staff criticizes the care given to the child before admission. It is very difficult to avoid this when one is faced with an obviously physically neglected child, or one who has been ill-prepared for admission. The hospital staff, naturally, has a strong reaction to the sight of a dirty, ill-clad or ill-nourished child. There is an equally strong reaction when a staff member observes a parent lying to a child about his admission, trying to skip away when the child isn't looking, or something of that sort. If the parent, at this point, is met by criticism, even in the manner of the staff member, his guilt may increase or he may feel threatened or resentful. He will become what we call the uncooperative parent, because actually he is not included in the team. We all know that we need the cooperation of the parent and yet we may unwittingly exclude him.

The separation of the parent from his child when he leaves him in hospital is probably the most painful part of the whole hospitalization. This is especially true if it is the first time that the parent and child have been away from each other. It is particularly hard when the child is very young and the hospitalization cannot be explained to him. Parents have often described the terrible feeling of loss when they leave their baby or small child in the hands of strangers. Naturally this is slightly lessened when the period before the first visit allowed is short and the visiting days are frequent. We know that in some countries the mothers are allowed to stay with small children. I believe that many mothers in this country would do so if it were possible. Some mothers who have been breast feeding their babies find it very hard to give this up. In some hospitals it is possible to arrange for this to be continued. Where it is not the practice most mothers would hesitate to ask for this privilege.

The day of admission is hard for the parents in another respect. Very often they have to wait for long per-

iods in the admitting department. There they may observe many terrifying things: such as the admission of children who are very ill, or have been injured. Some of these things appear gruesome to them. Sometimes the attitude and manner of the staff looking after these serious cases appear very off-hand and callous to a parent. They interpret the attitude of the staff by their own feelings and usually cannot see the difference. During this waiting time they go over all the things that they might have done to prevent their child's illness, and they wonder if they are doing the right thing to trust him to these strangers. If it is a question of elective surgery, these doubts will be aggravated. If the child is suffering from a congenital condition, they will go over and over their guilt and their questions as to the causes of his condition and their relation to their own behavior. They may feel guilty because actually they are glad to have him admitted because they have been ashamed of his condition, which may make him and them conspicuous. Maybe they have found it very difficult to love this child because he really appeared to be repulsive to them. If this is the case it will be very hard for them to leave him in the hospital because they cannot bear the feeling of relief at getting rid of him. It is actually what they have been longing to do right along but they knew it was wrong because the child is theirs and is their responsibility. They do not realize that few people can meet these problems without help. Unfortunately they are usually ashamed to ask for help.

Parents have various ideas about visiting the child in hospital. Some would like to come very frequently but are diffident about pressing this point. Sometimes, when the parents live out of town, they actually have no money with which to travel to see the patient. Very seldom would a parent like to explain this but would be much more likely to stay away and appear not to care. The same applies to parents who find it difficult to get to see the child in hospital because of the responsibilities in regard to the care of other children. Sometimes parents feel that they should not visit



because every time they do so, the child cries when they leave. They think they have upset him and that he will be better off if they do not see him at all. Some parents feel that they have no rights in regard to visiting — that they are interfering with the procedures on the ward. Some parents feel very inadequate as visitors. Their manner with the child will be unnatural because of the strange surroundings in which they find themselves. This is particularly true when any isolation procedure is necessary. They do not know what to talk about with the child. He has become a stranger to them. Sometimes they are too cheerful and unnatural. They are afraid to talk too much about the home in case he will be homesick. They don't want to tell him of anything that is going wrong in case he will worry. The relationship between parent and child becomes so unnatural that the parents cannot give the child the usual support and in turn the child cannot confide in the parent.

When the staff places all the attention on the child, to the exclusion of the parent, all these things are exaggerated and the parent comes to feel that he is quite unnecessary and is in the way. When the mother or father tells staff members of the child's habits or tastes and no one seems interested, they feel rebuffed or hurt. They lose confidence in these hospital people and begin to wonder how the staff can possibly understand their child or how they can give him proper care. At this point they may become very demanding because they are fearful and distrustful. They may mistake the brusqueness of a busy staff person for lack of interest in their child.

The hospital and the hospital staff present a real threat to parents. The staff of the hospital is doing everything in its power to ease the adjustment of the child to strange surroundings and painful procedures. This includes the giving of love and the giving of material things. It also includes a very permissive attitude with the minimum of discipline. The parents begin to worry about how they are going to manage when the child comes home. Some have a feeling of injustice. How can they follow the doctor's orders which include certain restrictions of

activity when the child has been so free in the hospital. They have a feeling that this is not fair to them. An only child may have been very happy with the group in the hospital. This presents another threat to the parents. If there has been disharmony in the home and an unloving atmosphere, the parent may worry about how happy the child will be when he gets home. When the child appears so happy in the hospital the parent may have a terrible feeling of jealousy. A mother may feel that the child will not love her any more, but will prefer the hospital staff.

Some parents who are loving may feel deep sorrow that they have not been able to give their child what he gets in the hospital. This is very well described in Gabrielle Roy's novel "The Tin Flute." There is a description of a child who lived in the poor part of the city and was admitted to hospital. The author tells of the joy of the child when he has his first orange and how he would look up at the nurse as at an angel. There is a very vivid portrayal of the mother visiting this child, observing these things and walking sorrowfully home with such deep regret that she could not give her child what she would like to have given.

This feeling of inadequacy is not only in regard to material things. Most parents have some fear that they will not be able to look after their child properly when they take him home. Some of them when questioned will protest that they can do so. They may be afraid that it will be suggested that he be sent to a convalescent home and they cannot bear a further separation or the idea that they are not fit parents. This fear may prevent them from asking necessary questions and from making sure that they understand about the care needed. Some of them feel that they do ask adequate questions but that they cannot get information. They say that they are always told such things as "that the child is doing as well as can be expected," or that his "condition is the same," or one of these stock phrases which only irritate. Some of the parents are so overcome by what they must face in the diagnosis or the prognosis that they actually do not hear what is



said to them by the doctor and they forget all the practical questions which they meant to bring up.

With all these fears, worries, doubts and other emotions in connection with the child's hospitalization, we realize

that the parent who comes to the hospital with her child, though she may have misgivings, has sufficient trust in the hospital staff to believe that something can be done to alleviate the child's suffering and distress

## Some Thoughtful Conclusions

MADELEINE FLANDER

### RESPONSIBILITIES OF THE NURSE

The nurse has technical responsibilities in the treatment of sick children and must be observant and meticulous in detail. She also must nurse the child as a person. To do this she requires information which will help her interpret the personal needs of her patients, namely, knowledge of growth and development, knowledge of play, and understanding of the hospitalization to the child and his family. Thus, with an adequate body of knowledge and understanding she could be expected to make nursing care plans for individual patients. With self-knowledge and practice she would be able to see and fulfil her own responsibilities.

To give this total care the nurse functions as a member of a treatment team and must have contact, communication and good relationships with others. She must know the general plan of medical treatment and rehabilitation. The nurse is the logical, central, focal point for integration of services to the child.

### IDEAS ABOUT THE ROLE OF THE NURSE

These depend to some extent upon the age and experience of the student. The older student may be less able to think of herself as a learner, less flexible and less able to accept teaching and supervision but she is likely to be more mature as a person.

The ideas of students about nursing relate often to physical care and treatment. To many, the ideal nurse is seen as being patient, perfect in techniques and routines, skillful and efficient, able to meet the patient's emotional needs,

kind, thoughtful, sympathetic, clean, neat and professional. She expects to be treated with deference and respect and to be able to restore order in chaotic situations. Most, automatically, expect the tidiness, the quietness and the smooth running routine care that is often possible in adult nursing.

In childrens' wards the student faces a different setting new kinds of relationships and a different focus and emphasis. Some of her ideas are interfered with. The children, the wards, the beds and she herself may get mused and untidy. Procedures may take longer because she has to establish a relationship and play with the children before starting to work. She is faced with problems of behavior, limitations and discipline. The atmosphere may appear much too permissive to her as her own ideas about discipline are interfered with. She may fail to grasp the real standards. She may expect all children to be attractive, pretty and to react to love, then find that this is not true. She finds that a larger number of her patients are completely dependent and demand much more of emotional giving from her. Frequently she shrinks from performing painful procedures upon infants and small children. She finds that she must recognize her role as substitute for the parent but must respect the rights of parents and correlate her work and behavior with them. They may be very distraught, upset, overprotective or neglectful.

The nurse's reactions may include feelings of inadequacy, frustration, fatigue, tension, guilt, fear, dislike. These are normal but students need help with them if the pediatric experience is to be a positive influence in their

personal and professional growth.

#### SUGGESTIONS FOR HELPING STUDENTS

Careful screening and selection of applicants before admission to schools of nursing are basic to effective student nurse training programs. These young women come in training with great enthusiasm for the task ahead and the faculty members should try to help them maintain and channel this enthusiasm.

Sound basic training in the principles of nursing practice will help the student to feel secure in carrying out her responsibilities.

Head nurses, teachers and directors of nursing should establish effective working relationships with students. It is their responsibility to help the student establish satisfying work and play relationships with her fellow students when she seems to need help of this kind.

The student should be involved, when she is ready, in planning ward procedures and policies and share in the responsibility for carrying out the plans. She should be helped to understand that she is a vital member of the ward team. One of the steps in achieving this is by giving her a complete orientation to departments of the hospital.

The rights of the student as a person should be respected. She should know in advance of proposed changes in her ward assignments or affiliations. Her welfare and interests should be considered in scheduling her free time and her hours on the wards. She has need of recognition for a job done well.

The advent of modern treatment with the sulfone drugs is completely altering the psychological aspect of leprosy. The frequent need for only a short isolation period followed by home treatment or periodic visits to a clinic, the arresting of the disease by modern therapy, making it non-transmissible and effecting apparent cures, are breaking down the age-old attitudes and prejudices of the public that make outcasts of the victims of this disease.

Almost all countries have legislation on leprosy, but an essential factor in any anti-leprosy campaign is adequate, up-to-date legislation aimed at prevention of the disease.

The student should be briefed fully prior to entering any new learning situation and especially when it involves an affiliation in another hospital. She should be told realistically about what to expect in the new situation and helped to understand why the experience is considered to be a necessary part of the program. Older students might help to interpret to younger students.

Levels of performance expected of the student nurse should relate to her previous experiences and individual capabilities. There should be an effective grading of the responsibilities she will assume so that she may prove adequate for them.

The affiliating hospital has a responsibility to see that new students are introduced to the new situation and that they receive a clear picture of what is expected of them.

On return to the home school, guidance should be given to students to help them integrate new ideas and skills into their total nursing experience.

There should be interchange of information and ideas between all home hospitals and their affiliating schools since the student is best served when training programs are coordinated.

Reports, records, interviews and other methods should be used to help various staff members to know and assist the student.

All students are apt to suffer a mid-training slump. This is a normal occurrence and the staff should expect and plan for it. Curriculum plans should provide for the increased support and recognition which the student will need at this time.

early and more adequate diagnosis and treatment. The organization of a campaign for the eventual extirpation of leprosy from the Western Hemisphere has been advocated. The possibility of eradicating leprosy exists today, just as in the case of syphilis or smallpox but, as in the case of those diseases, it would be far from an easy or inexpensive task.

— PAN AMERICAN SANITARY BUREAU

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It is a man's own fault, it is from want of use, if his mind grows torpid in old age.

— SAMUEL JOHNSON



# LE SOIN DES ENFANTS

SUZANNE GIROUX

**A**U COURS DE MES VISITES dans les écoles d'infirmières, l'on se plaint dans presque tous les hôpitaux généraux de la difficulté éprouvée au recrutement d'infirmières pour le service de pédiatrie et particulièrement pour les pouponnières. A quoi attribuer cette difficulté?

C'est ce que nous allons ici essayer de trouver. Les qualités du cœur ne sont certainement pas en cause car nos infirmières sont généreuses et dévouées. S'agirait-il d'un manque d'intérêt envers les enfants? Peut-être! Manque d'intérêt qui pourrait s'expliquer par une connaissance insuffisante de l'enfant et des soins qu'il requiert.

Nombre d'infirmières ont été formées par des surveillantes n'ayant reçu pour toute formation que celle que donne le cours de base; malgré toute leur bonne volonté, elles ne pouvaient donner ce qu'elles-mêmes n'avaient pas reçu. Il y avait aussi la pénurie de manuels en français sur les soins à donner aux enfants et jusqu'à ces dernières années un petit nombre de pédiatres.

Le fait de passer d'un service de malades à celui de la maternité qui est presque toujours dans nos hôpitaux logé sous le même toit fait quelquefois oublier que l'obstétrique est de la médecine préventive. Les infirmières sont portées à considérer les nouveaux-nés comme des petits malades et comme il n'y a pas de maladie le service semble monotone et il en résulte un manque d'intérêt. Souvent, aussi, la surveillante éprouve le même sentiment que l'infirmière de service; elle occupe ce poste par devoir; qu'y a-t-il d'intéressant, dit-elle, à changer des couches, à donner des biberons, à porter les bébés aux mères, j'ajouterais *le moins souvent possible!*

Que de beaux programmes nous pourrions amorcer dans nos maternités si nos infirmières connaissaient mieux

le développement de l'enfant, cette merveille, le transfert affectif entre la mère, ou le substitut de la mère, et l'enfant, les facteurs psycho-sociaux pouvant affecter la famille; l'infirmière formée à toutes ces connaissances comprendrait mieux l'importance de son rôle, la grandeur de sa mission.

Comment expliquer, autrement que par le manque de compréhension et de connaissance, le taux élevé de la mortalité infantile dans notre province, le plus haut de tout le Canada! Le grand nombre de naissances serait la cause d'enfants faibles? Il semble que les progrès accomplis ces dernières années sont la preuve du contraire.

Le niveau de vie est-il bas? Les salaires n'ont jamais été si élevés et notre niveau de vie ne se compare-t-il pas avantageusement à celui des autres provinces?

A mon avis, le manque de préparation des infirmières enseignantes et surveillantes en pédiatrie et particulièrement chez les nouveaux-nés, est un des facteurs contribuant à maintenir un taux élevé de mortalité chez les enfants. Je m'appuie, en m'exprimant ainsi, sur les paroles suivantes extraites du rapport technique de l'OMS No. 24, du Comité d'experts des soins infirmiers:

Les infirmières qui assument des fonctions d'ordre pédagogique dans les écoles d'infirmières de toutes catégories doivent avoir bénéficié d'une préparation complémentaire supérieure à celle que comporte l'enseignement de base.

Et voici d'autres paroles qui sont de nature à nous faire réfléchir en considérant le taux élevé de notre mortalité:

Il est intéressant d'observer que, dans les pays où le perfectionnement des soins infirmiers ne va pas de pair avec les progrès de la médecine, l'état de santé de la population ne reflète pas ces progrès.

Quel est cet enseignement supérieur que doit recevoir l'infirmière?

Premièrement, une connaissance approfondie de la matière considérée sous tous ses aspects. Si l'infirmière se destine au soin des nouveaux-nés, ces

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Mlle Giroux est visiteuse officielle pour les écoles d'infirmières françaises de la province de Québec.



études couvriront tout le cycle de la grossesse. Le but de l'infirmière dans une pouponnière est de donner des soins experts aux nouveaux-nés et aussi d'aider les membres de la famille à se préparer, à comprendre et à se tirer d'affaire dans toutes les situations qui peuvent se présenter; elle doit aussi contribuer à l'amélioration constante des soins aux nouveaux-nés. L'infirmière a donc trois tâches à remplir: donner des soins aux enfants; établir des relations parents-infirmière; et enseigner.

Pour bien connaître la matière, il ne suffit pas de travailler pendant quelques mois dans un service; l'infirmière devra suivre un programme spécialement préparé et dirigé par une autorité compétente, ordinairement une université.

Deuxièmement. Le programme doit comprendre un enseignement théorique et un stage pratique dans un ou plusieurs hôpitaux et dans les cliniques maternelles des services de santé. Le programme théorique comprendra l'étude des statistiques, rapports et manuels sur la matière.

Parmi les infirmières qui s'inscrivent pour ces cours, on choisira de préférence celles ayant au moins une année d'expérience en obstétrique. La surveillance de ces étudiantes sera confiée à l'institutrice chargée du cours. C'est elle qui assurera la coordination de l'enseignement et de la pratique, de même que l'intégration de l'enseignement de l'hygiène — physique et mentale — dans la famille, lors des visites à la clinique et à l'hôpital.

Il va sans dire qu'une infirmière se destinant à donner des soins aux nouveaux-nés approfondira ses connaissances de l'enfant. L'infirmière doit viser à devenir experte dans le domaine où elle exerce et ce qui est nécessaire pour interpréter intelligemment les besoins du nouveau-né et lui apporter tous les soins immédiats et continus durant la période néonatale. Pour atteindre ce but, voici les connaissances, qu'elle doit posséder:

1. Connaître et comprendre le développement de l'oeuf fécondé, de la conception à la naissance.

2. Habileté à préparer et à exécuter les soins aux nouveaux-nés. Pour atteindre ce but il faut connaître le mécanisme respiratoire de l'enfant avant sa

naissance, comment s'établit la respiration, les changements physiologiques qui s'opèrent à la naissance et durant la période néonatale; dilatation des bronches, équilibre de la respiration pulmonaire, conservation de la chaleur, digestion, équilibre du métabolisme, de l'eau, la sang à la naissance et durant la période néonatale, tendances du nouveau-né à contracter certaines maladies, etc.

3. Habileté à évaluer les soins dont le nouveau-né a besoin et à lui donner ces soins:

- A. Connaître les besoins de l'enfant et être capable de lui donner les soins dont il a besoin, par exemple:

- (i) Connaître et appliquer les moyens de réchauffer le nouveau-né et conserver la chaleur du corps.
- (ii) Connaître et donner avec habileté les soins concernant le cordon ombilical, les yeux, les médicaments, etc.
- (iii) Connaître les méthodes d'identification des nouveaux-nés, aspects légaux.

- B. Habileté à observer et à apprécier l'enfant normal au point de vue physique et psychique afin de noter toute déviation et les rapporter immédiatement. Pour cela il faut être habile pour mesurer, peser le bébé, observer les os, les muscles, fontanelles, la position, la coordination des mouvements, la peau, yeux, oreilles, nez et bouche; les pleurs, expression de la face, respiration; le sommeil, l'alimentation, l'élimination, la température et les organes génitaux.

- C. Habileté à tracer des plans de soins à donner aux enfants déviant de la normale. Pour cela il faut connaître:

- (i) Les signes et symptômes des conditions suivantes: atelectasie du nouveau-né, traumatismes crâniens, paralysie, maladie hémorragique du nouveau-né, difficultés des prématurés.
- (ii) Connaître les troubles émotionnels que peut causer au sein de la famille la naissance d'un enfant anormal et être capable d'aider la famille à s'adapter à une telle situation.

- D. Faire connaître davantage les principes qui sont à la base de l'alimentation

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(1) *Guide for an Advanced Clinical Course in Obstetrics*, National League for Nursing.

de l'enfant, la technique de l'alimentation maternelle, l'adoption par la mère et l'enfant de l'alimentation artificielle. Pour cela l'infirmière doit connaître:

- (i) Le rôle des hormones dans la lactation.
- (ii) Les facteurs physiques et psychiques favorisant une bonne alimentation maternelle chez les nouveaux-nés.
- (iii) La technique de l'alimentation.

E. Habileté à travailler avec la mère et le père pour leur aider à faire des plans à l'avance en vue de la naissance de l'enfant afin de leur permettre d'organiser la vie de la famille. Pour cela elle doit être capable:

- (i) D'évaluer les besoins de la famille après avoir analysé son attitude, ses réactions et le milieu.
- (ii) Expliquer les besoins particuliers du nouveau-né.
- (iii) Expliquer les principes du soin des enfants, de leur développement, en tenant compte des conditions économiques, sociales et émotionnelles de la famille.

Troisièmement, utiliser adéquatement les ressources qu'offre la communauté afin de répondre aux besoins sociaux et économiques de la famille

et d'en assurer la santé.

Voilà les connaissances que doit posséder une infirmière appelée à donner des soins intelligents aux nouveaux-nés; il va sans dire que si une de ces infirmières est appelée à devenir surveillante ou institutrice, elle devra se préparer à cette nouvelle tâche.

L'infirmière spécialisée en pédiatrie, en plus des connaissances que nous venons d'énumérer, devra continuer à étudier le développement normal de l'enfant afin de pouvoir en reconnaître les déviations, les moyens de les prévenir et de les corriger.

Il serait trop long de donner dans le cadre de cet article les détails du cours. Qu'il suffise de rappeler que le soin des enfants demande une préparation dépassant celle que réclame le soin des adultes. L'enfant en santé ou malade ne se révèle qu'à ceux qui le connaissent et ainsi le comprennent. C'est un être mystérieux renfermant tout un passé et dont l'éveil à la vie se fait entre nos mains.

Espérons que nos enfants seront accueillis par des infirmières compétentes, c'est-à-dire renseignées, compréhensives et sympathiques.

## Ontario

The following are staff changes in the Ontario Public Health Nursing Services:

**Appointments** — *Noreen Noonan* (Charlottesville Hosp., Univ. of Toronto) to Deep River. *Ila (Wilton) Tuff* (St. Thomas Memorial Hosp., Univ. of West. Ont.) to Elgin-St. Thomas H.U. *Marilyn (Spear) Wilson* (Toronto Gen. Hosp., Univ. of West. Ont.), *Lois (Eddie) Suggitt* (Ottawa Civic Hosp., U. of T.), *Julia Liphardt* (T.G.H., U. of T.), *Mary Rust Moore* (T.G.H., U. of T.), *Celeala (Maloney) Percival* (St. Michael's Hosp., U. of T.) to Etobicoke Township B.H. *Elizabeth Zadanyi* (Hamilton Gen. Hosp., U. of T.) formerly with Kent Co. H.U. to Haldimand Co. School Health Service. *Mavis Barker* (U. of A.) to Hamilton Dept. of Health. *Florence Stewart* (T.G.H., U. of T.) to Halton Co. H.U. *Lassy Malowany* (Winnipeg Gen. Hosp., U. of T.) formerly with North York Township B.H. to Kenora-Keewatin-Dryden Area H.U. *Lillian (Garrett) Stewart* (Ottawa Civic Hosp.,

McGill Univ.) to Leeds and Grenville H.U. *Ethel Tingley* (O.C.H., U. of T.) to Lennox and Addington H.U. *Joan Cogdon* (Metropolitan Hosp., Windsor, Univ. of West. Ont.) to Board of Education, London. *Katherine Buchan* (Victoria Hosp., London, Univ. of West. Ont.) formerly with Kent Co. H.U. to Middlesex Co. School Health Service. *Jean Marshall* (Wellesley Hosp., U. of T.) and *June Schaefer* (Toronto East Gen. Hosp., U. of T.) to Scarborough Township B.H. *Joan Thomas* (Cornwall Gen. Hosp., U. of T.) formerly with Fort William and District H.U. to Simcoe Co. H.U. *Florence Tomlinson* (Kitchener-Waterloo Gen. Hosp., Univ. of Pennsylvania, U. of T.) to the position of supervisor, Sudbury District H.U. *Geraldine Quantz* (Kingston Gen. Hosp., U. of T.) formerly with Wellington Co. H.U. to Timiskaming H.U. *Mary Molloy* (Prince Rupert Gen. Hosp., U. of T.) to Wentworth Co. H.U. *Ann (Breen) Bobbett* (St. Jos. Hosp., Toronto, Dalhousie Univ.) to York Township B.H.



# Staphylococcal Pneumonia

CLARA DEMKO

## SOCIAL HISTORY

MRS. BELL was born in England — one of a family of seven children. She completed the equivalent of junior matriculation before going to work as chief cook in the home of a wealthy doctor. When she was 23 years old she came to Canada where she eventually married a C.P.R. locomotive engineer. Mr. Bell died 18 years ago from coronary thrombosis. Mrs. Bell is an intelligent, interesting person with a lively sense of humor.

## MEDICAL HISTORY

Mrs. Bell's mother died as a result of acute appendicitis and her father succumbed to apoplexy. Her own childhood diseases had consisted of measles and mumps. Mrs. Bell has had several upper respiratory infections complicated by laryngitis. At no time has she undergone surgery.

She is the mother of eight children of whom seven are alive and well. One daughter died as the result of a heart condition when she was 27 years old. Mrs. Bell's present admission to hospital was made necessary when she developed a severe case of staphylococcal pneumonia.

## DEFINITION

Pneumonia is an acute infectious inflammation of lung tissue in which there is a consolidation or filling of alveoli in infected areas with inflammatory exudate. It is either bacterial or non-bacterial.

Staphylococcal pneumonia is a comparatively rare form of pneumonia. Infection spreads to the lungs from the upper respiratory tract. The distribution is usually lobular and the formation of multiple minute abscesses in the

lungs is characteristic. The mortality rate is extremely high — usually 80 per cent of the cases are fatal. *Staphylococcus aureus* — the causative organism — occurs typically in grape-like clusters. It is gram-positive, non-motile, does not form spores and produces a characteristic yellow pigment. It is the most resistant of non-spore-forming organisms.

## SYMPTOMS

### Usual Symptoms:

1. Severe chills.
2. Sharp chest pain due to pleurisy — rubbing together of pleural surfaces.
3. Dyspnea — caused by interference with free exchange of gases between blood and air due to exudate in alveoli.
4. Respirations rapid, shallow, painful, each inspiration punctuated by a grunt.
5. Cheeks flushed, eyes bright, lips cyanosed.
6. Cough — short, painful, incessant, productive, due to irritation of bronchi.
7. Pulse rapid and bounding.
8. Temperature rises rapidly and may reach a level of 104° to 106°F., due to toxins.
9. Patient feels exhausted, dizzy.
10. Loss of appetite.
11. Patient may exhibit a restless, excited delirium.

Mrs. Bell's symptoms followed this pattern fairly closely. She had frequent chills and severe pain in the left anterior chest. Her respirations were labored and painful, 32 per minute, with considerable dyspnea and cyanosis. She had a troublesome, croupy, productive cough, with blood-tinged sputum. Admission temperature was 102.6° with the pulse 120. Mrs. Bell was very upset and restless, unable to lie still in one position for any length of time. She said she felt "all worn out."

## LABORATORY FINDINGS

Upon admission, several laboratory

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Miss Demko was a senior student at the Galt School of Nursing, Lethbridge, Alta., when she carried out this study.



tests were done. The white blood count was 17,000 which signified an infection present since the normal is from 5,000 to 9,000. The red blood count was within normal range. The hemoglobin — 11.1 gm./100 cc. of blood — was below the normal of 15 gm./100 cc. The differential count showed the presence of leukocytosis — a result of the demand for enormous numbers of leukocytes to be poured into the alveoli of the lungs. The urinalysis was essentially normal except for a few bacteria, epithelial cells and hyaline casts.

Several sputum cultures were done. At first growths of *Monilia albicans* and a heavy flora of gram-positive cocci in clusters appeared. Finally, after repeated cultures, the causative organism, *Staphylococcus aureus* was identified. It is sensitive to Ilotycin and Chloromycetin.

### X-RAY FINDINGS

The first chest x-ray on admission showed a lobar consolidation involving the whole left lower lobe. There was a moderate degree of atelectasis and a thin-walled cavity in the centre of the lobe, 3 cm. in diameter. An x-ray taken 19 days later showed some improvement. There was still a large consolidation with some element of atelectasis in the lower lobe where the cavity continued to be seen. The diaphragm was assuming a more normal position. The final x-ray showed further regression in the lobe. There was still a thin-walled cavity in the apex.

In this case, the cocci passed down the trachea and bronchi and involved the alveoli. An inflammatory exudate poured from the vessels into air spaces. The exudate consisted of leukocytes, serum and fibrin threads. Many of the capillaries gave way and red blood corpuscles were added. This caused a complete replacement of air normally present — that is, the lung no longer contained air in the lobe, but exudate. Slowly the exudate disintegrated, softened and was coughed up as blood-tinged sputum.

### MEDICAL TREATMENT

The primary objective of the medical treatment was to help the natural protective agencies of the body conquer

the disease. It was important to identify the causative organism and then treat the condition medically with the specific drugs.

### NURSING CARE AND TREATMENT

The chief objective of the nursing care was to maintain physical and mental rest. Bed rest was essential, particularly where fever was present. Mrs. Bell had to be kept as comfortable as possible by means of daily baths, back rubs, ample back support, good oral hygiene, regular elimination and adequate ventilation. Unfortunately, she occupied a ward bed, thus was not able to get as much rest as was necessary. She was moved frequently from side to side to help prevent any further pulmonary complications.

An abundance of water and other fluids was required. A patient with pneumonia frequently has a chloride deficit so that it was necessary that sodium chloride be supplied in liberal amounts.

During the acute stage when the patient did not feel like eating, high caloric fluids were given. As Mrs. Bell's condition improved her diet was increased from a fluid to a soft diet.

As she improved, deep breathing exercises were ordered to be done four times daily. These assisted greatly in re-expansion of the lung. This is an extremely important aspect in the nursing care. Postural drainage was also ordered preceding the deep breathing exercises. Postural drainage is a procedure whereby the patient lies over the side of the bed, with his head down, enabling the purulent sputum to drain from the lower lobes of the lungs.

Gradually, Mrs. Bell was able to sit up in a chair for ten minutes each day. This period was slowly increased until she was able to walk with assistance.

### MEDICATIONS

On admission to hospital, Mrs. Bell received crystalline penicillin, 250,000 units every six hours intramuscularly. This was an antibiotic to prevent any further infection and to treat infection present. The penicillin did not appear to bring much improvement so sulphadiazine, tablets 2, was given orally

every six hours. Still the patient did not show improvement. S.R. Penicillin 400,000 units intramuscularly every 12 hours was substituted. Finally, when the causative organism was isolated and identified, Ilotycin 200 mg. and Chloromycetin 500 mg. were given every six hours. It was found that these two antibiotics were the only ones to which the *Staphylococcus aureus* was sensitive.

Digitalis folia gr.  $\frac{1}{3}$  was given twice daily to relieve symptoms of congestive heart failure since it acted as a cardiac tonic.

Mrs. Bell was given 1,000 cc. of blood while in hospital to raise her hemoglobin level. Her hemoglobin at the time of discharge was 11.85 gm.

Since rest and sleep were very vital codeine gr. 1 orally was given as necessary to relieve chest pain.

#### HEALTH TEACHING

Mrs. Bell was a very active person. It was necessary to impress upon her the importance of absolute rest and quiet. She was very independent and wished to do a great deal for herself.

It was necessary to teach her the importance of cleanliness and mouth care for comfort as well as for hygienic purposes and the use of sputum cups to prevent the spread of infection.

It was explained to her that good nourishing food and drinking large quantities of fluids were important. The value of postural drainage and deep-breathing exercises was stressed as well as the necessity of moving frequently from side to side. She had to guard against over-activity and take special precautions against upper respiratory infections.

#### CONVALESCENCE

A long convalescent period was necessary for Mrs. Bell — one that had to be carefully planned and followed. Because of her age complete recovery was a slower process especially since she was prone to upper respiratory infections. It was necessary to limit her activity and to be certain that she had ample rest, nutritious food, sleep and fresh air. All possible measures had to be taken to prevent colds and chilling.

## In The Good Old Days

(*The Canadian Nurse* — DECEMBER, 1916)

It is estimated that 25 per cent of our criminals, juvenile and adult, belong to the moron class. These people are expert imitators. Possessed of little originality, they succeed in adopting the manners and customs of their fellows; they learn how to converse in parrot-like fashion, dress in the latest style, and up to a certain level, appear quite like other people.

\* \* \*

Inoculation against typhoid fever has produced a remarkable diminution of that disease among the troops. In two months of 1915 there were 10,869 cases of typhoid reported from the army. In the corresponding period this year there were only 1,798 cases and most of these were in men who had refused inoculation.

\* \* \*

A baby contest was held under the auspices of the local Victorian Order of Nurses.

There were over 300 babies. There were eight pairs of twins and one set of triplets, the latter being a great source of curious interest as no one there had ever seen such a trio before. The fond mother was only too proud to have them displayed.

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Operation for tonsils and adenoids often fails to relieve habits of faulty articulation and consequent school retardation. Vocal drill by one trained in speech disorder is the surest way to secure speedy permanent improvement.

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A fund of humorous stories is an excellent asset for anyone who is obliged to be around the sick. Nurses should keep a small book to jot these stories down so that whenever the condition of her patient will warrant a little pleasantry, they will have stories available.



# A Greenhorn on the Frontier

RUTH E. EVANS

**I**T WAS SHORTLY AFTER we went north. We were going to have chicken for dinner. When I went to get the bird ready, I discovered that it had not been cleaned. I thumbed frantically through my big cookbook to find out how it was done! "Take it to your nearest butcher!" it said. With my nearest butcher over a hundred miles away, this was some help! I decided my motto would have to be "Do it yourself!"

So it was with my nursing, I soon found. Who else was there to make the decisions, do the diagnosing, and dispense the drugs? The nearest doctor was also over a hundred miles away.

We had come north, my husband and I, a few weeks earlier. In order that we could spend at least part of the year together I was to establish a nursing service for the Red Cross along 200 miles of the Hudson Bay railroad in northern Manitoba, between Wabowden and Gillam, while my husband was going to teach at Wabowden. We had set up housekeeping in a railway car, which was reconverted to be a "nursing station on wheels."

There were living quarters at one end, while the other end was fitted up as a combined office and examining room, with one emergency bed. In winter, the car was stationed three months at Wabowden and three months at Gillam in order to be connected to the steam. We also had electricity and running water at these points. In summer, the car would visit smaller places along the line.

Fresh from a public health nursing course, I was filled with enthusiasm and ideas for teaching health to everyone! It was all I could do to keep from falling into the trap, as so many of us do, of trying to "change the world in a day."

I soon found out that most of my "flock" were not very interested in any organized program, such as pre-

natal classes or well-baby clinics. I had to rely on "teaching in the home."

I set out to visit all the families, about eighty in all. One of my first calls was to a woman whose baby had almost died that summer with infant diarrhea. After working around to the question of boiling the water etc., I asked her if she had boiled the bottles and nipples. "No," she said, "What is the use? My baby only goes out and eats dirt anyway!" I still haven't thought of a good answer to that one! And so it was with most of my efforts.

I found living conditions that were both good and bad. In one home, the mother was extremely particular. Her place was scrubbed and polished until it virtually shone. It was a joy to visit her. On the other hand, there were others along the line that were terribly overcrowded, and negligently cared for.

It was a busy year. There had been no regular nursing service previously. Inoculations had been done only sporadically and just the year before there had been quite an epidemic of whooping cough with resultant infant deaths. I set about inoculating on almost every visit I made. We did not have an epidemic that year, and I like to think that perhaps my efforts were not in vain.

Of course, the public health side was only a small part of my work. The sick calls and emergency nursing took up most of my time. The latter was, perhaps, the most important of all. For it is with accident cases or a sudden severe illness that many lives are lost in these lonely isolated places of the bush. It is at such times that the nurse is most appreciated. It made me feel that nurses throughout the north are filling a very definite need.

As I look back now on my own experiences, I can recall several such incidents in my short time "in the bush."

I shall cite only two. I can remember the time that I was called to care for a boy, about 18 years of age, who had

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Mrs. Evans is still working in the northland, residing now in Rupert's House, Quebec.



cut his foot badly with an axe. It was the middle of winter and he had walked home several miles through the bush to reach aid. We arrived at the dwelling about 8:00 p.m. I saw at once the cut would require several stitches. By the light of the one coal oil lamp and a small battery lamp that my husband held, I set to work. I was sure that the wound would become infected, but miraculously nothing so serious happened. Several days later the lad was up and about.

How vividly I can recall, too, another time when I was called to a sick two-week-old baby. All I could get out of the girl who came for me was that the baby "had gone blue." Thinking it must have taken a convulsion, and that probably I could do nothing, I set out with her with some reluctance. We arrived at the home about ten o'clock. The room was filled with kindly neighbors. Although it was mid-winter, it was terribly hot inside the small cabin. I was handed a small bundle of blankets. As I carefully unwrapped each one, I could sense that all eyes were on me. I took one look at the baby and knew that I had to do something, and do it quickly — just what I did not know! The baby was terribly cyanosed, and hardly breathing at all. Without stopping to take off my parka, I prepared Coramine and then started in with artificial respiration. (I could think of nothing else to do!)

Victoria, B.C. would appear to lead among Canada's principal cities in the proportion of aged in its population, with 17.75% of its citizens over the age of 65. Other cities with a high percentage of the aged are Vancouver 12.81%, Toronto 10.51% London 10.49% and Winnipeg 9.8%. On the other hand Quebec, the nation's oldest city, has only 5.92% of its people over age 65, and Montreal 6.37%. Windsor and Halifax are the only other cities with a figure below 7.

These figures were compiled by Dr. James Tyhurst of the Allan Memorial Institute, Royal Victoria Hospital, Montreal, who made a study of the social situation of elderly citizens under a Federal-Provincial grant. This study shows Canada as a country which is "aging" rapidly. Since 1881 Canada's population has increased by three times, while the percentage of those over 65 has jumped by six times.

The baby would take a breath and stop, then take another. I felt so helpless! It was such a fine little boy! I silently breathed a prayer and worked on, quite oblivious to my surroundings. After awhile, I was aware of the room gradually emptying, until only the mother and father and I remained. By midnight, the infant's respirations had returned almost to normal and the color had come back. We gave him a little milk before I left. I made several return visits to give penicillin and he recovered completely. To me, it was nothing short of a miracle that the baby lived at all! Several months later the mother brought him in to be weighed. He had grown so much and she was so proud of him.

There were dozens of other cases, of course, that were not so dramatic, but each of them was interesting and sometimes amusing. Life was far from dull! I realize that there are many other nurses who have had far more experience than I. However, does not this life present a challenge to those who like adventure?

There is still a great need for nurses throughout the north. Certainly it is, at times, a great responsibility and the decisions one must make are not always easy. But the life has its rewards — the reward of grateful people, like the young mother in my story. Yes this "frontier nursing" is a challenge for today!

Taken by provinces, Quebec is the "youngest" with 5.7% over 65. The others: Newfoundland, 6.5; Prince Edward Island, 9.9; Nova Scotia, 8.5; New Brunswick, 7.6; Ontario, 8.7; Manitoba, 8.4; Saskatchewan, 8.1; Alberta, 7.1 and British Columbia, 10.8.

When it comes to distribution, about 60 per cent of aged live in Quebec and Ontario, but in trends the Western provinces are getting "older" much faster than the east. The percentage of increase in the rate of aged in Quebec since 1881, for instance, is 398 compared with 6,546 in Manitoba and 10,146 in British Columbia.

In 1951, the total over 65 in Canada was 1,086,273 or about 7.7 per cent, which puts Canada in 16th place in the list of countries according to percentage of aged. England and Wales are aging rapidly, with a 1951 figure of 10.8 compared with only 7.5, about our level back in 1931.

# Nursing Profiles

October 19 was a day of rare excitement at the University of Western Ontario when **Edna Lena Moore**, Director of public health nursing for the Ontario Department of Health, received the honorary degree of Doctor of Laws, then delivered a convocation address.

Born in Ontario of Irish parentage, Dr. Moore has had a rich and varied career in nursing. After graduating from Toronto General Hospital in 1913, she joined the staff as night supervisor, later becoming head nurse in the emergency department. In 1915 she enlisted with the C.A.M.C. and served in France, England and the Middle East. She was made an Associate of the Royal Red Cross in appreciation of her work.

Returned from overseas in 1919, Miss Moore served for a year as social service nurse with the Soldiers' Civil Reestablishment, then joined the division of preventable diseases of the Ontario Department of Health. In 1925 she accepted a position as supervisor of venereal disease nursing in Olean, N.Y. but returned to Canada two years later as home nursing teacher for the Ontario Department of Agriculture. From 1927 to 1929 she was a field worker for the Canadian Tuberculosis Association following

which she spent two years in New York as an assistant director with the National Organization for Public Health Nursing. After several years as chief public health nurse for the division of maternal and child hygiene in Ontario, she assumed her present position in 1944.

Dr. Moore has been active on the boards of many organizations including a term as president of the Ontario Public Health Association. She is a charter member of the Soroptimist International of Toronto.

Several new appointments have been made to the faculties of university schools of nursing across the land this autumn. **Alberte Roy** is assistant director of the division of public health nursing, School of Hygiene, University of Montreal. A graduate of Hôpital Ste-Jeanne d'Arc, Montreal in 1930, she holds her B.Sc. in supervision in schools of nursing and her M.A. from Teachers College, Columbia University, majoring in administration in public health nursing. In addition to many years of hospital experience including supervision of the obstetrical department, and later the emergency and x-ray units at Misericordia Hospital, New York, staff work at the Montreal Neurological Institute and at a small Red Cross Hospital in Ontario, Miss Roy has practical knowledge of the problems of district public health nursing. She was on the staff of the Gaspé East health unit for nearly three years, the last half of which she was educational director.



EDNA L. MOORE



ALBERTE ROY



**Ruth Elizabeth McClure** is assistant professor of nursing in the School of Nursing at the University of Alberta. Graduating with the degree of B.Sc. from U. of A. in 1942, Miss McClure later obtained her Master of Public Health degree from the University of Pittsburgh. In her chosen field of public health nursing she has had considerable experience in health unit work in Alberta and also in the Venereal Disease Division of the Toronto Department of Health. For a short time she was secretary of the Toronto Branch of the Health League of Canada.



**RUTH E. MCCLURE**

**Vivian B. Kirkpatrick** is an instructor in public health nursing with the University of Western Ontario School of Nursing. A graduate in 1942 from Women's College Hospital, Toronto, Miss Kirkpatrick secured her public health certificate from the University of Toronto School of Nursing, later receiving her B.N. from the McGill School for Graduate Nurses, majoring in supervision and administration in public health nursing. Several years in hospital work preceded Miss Kirkpatrick's entry into the public health field on the staff of Brant County Health Unit. After two years as health supervisor in the W.C.H. school of nursing, she joined the World Health Organization going as nursing specialist to Formosa. Later, under the Canadian Colombo plan, she was nursing adviser at the Lady Harding Hospital in New Delhi, India. This world travel has given Miss Kirkpatrick a won-

derful opportunity to add to her interesting collection of international dolls.

**Mary L. Richmond** is director of nursing at Royal Jubilee Hospital, Victoria, B.C., where for four years earlier she had served as educational director. A graduate from Vancouver General Hospital, Miss Richmond holds her B.N. from McGill School for Graduate Nurses and her M.A. from Teachers College, Columbia University. She was on the teaching staff at the Vancouver General for several years.



**MARY L. RICHMOND**

**Sister Noémi de Montfort** has taken over her duties as administrator at Ste.



**SISTER NOÉMI DE MONTFORT**



Justine Hospital, Montreal, where she had graduated in nursing 15 years before. Sister Noémi's postgraduate work included preparation in hospital organization and management at the Institut Marguerite d'Youville, Montreal. She was made a fellow of the American College of Hospital Administrators in September, 1956. She succeeds Sister Valerie de la Sagesse who has been forced to retire because of poor health.

A graduate of the Hospital for Sick Children, Toronto, **Dorothy G. Hollister** is now the director of nursing at the New Queensway General Hospital, Toronto. Postgraduate study in obstetrics and later in administration of nursing service, at the University of Toronto School of Nursing, plus broad experience in hospital administration have given Miss Hollister a strong background for her new work. She has served as superintendent of Douglas Memorial Hospital, Fort Erie, Ont., of the Great



SOEUR VALERIE DE LA SAGESSE

War Memorial Hospital in Perth, Ont., as assistant director at Sarnia General Hospital and, immediately prior to her new appointment, as director of nursing at South Waterloo Memorial Hospital in Galt, Ont.



DOROTHY G. HOLLISTER

**Soeur Valerie de la Sagesse** quittait à l'automne son poste de directrice de l'Ecole d'Infirmière de l'hôpital Ste-Justine pour celui de consultante en nursing au nouvel hôpital.

Diplômée de Ste-Justine en 1919, Soeur Valerie devenait en 1924 directrice de l'école. Educatrice dans la force de l'âme, elle forma des générations d'infirmières s'efforçant de développer autant leurs qualités personnelles que professionnelles. Durant trois ans elle fut présidente de l'Association des Infirmières de la Province de Québec et montra dans l'exercice de ces fonctions un jugement sûr, un esprit de prévoyance et un grand amour de la concorde. Nous prions Soeur Valerie d'accepter tous nos meilleurs vœux.

## In Memoriam

**Ethel Hilda (Hennie) Anderson**, who graduated from Misericordia Hospital, Edmonton, in 1924, died on February 25, 1956 in Toronto. Mrs. Anderson began her pro-

fessional career as a floor supervisor at her Alma Mater. In 1927 she became maternity supervisor at the Red Deer Hospital. Ten years later she was made night superin-

tendent at Wellesley Hospital, Toronto. From 1947 until her death, Mrs. Anderson was Provincial Nursing Officer with the Ontario Council of St. John Ambulance.

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**Margaret (McCullum) Beach**, who graduated from the Ottawa Civic Hospital in 1926, died on August 4, 1956, after a short illness. Prior to her marriage, Mrs. Beach was on the staff at O.C.H.

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**Audrey Bernice Elliott**, who graduated from Winnipeg General Hospital in 1953, died suddenly at Moose Jaw, Sask., on September 2, 1956. Miss Elliott had worked at the General Hospitals in Vancouver and Brandon prior to joining the staff of Moose Jaw Union Hospital last June.

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**Gladys Ellis**, who graduated from Saskatoon City Hospital in 1935, died recently.

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**Kathleen G. (Trainor) Farrell**, who graduated from St. Paul's Hospital, Vancouver, in 1924, died on September 10, 1956.

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**Ella Maude Forrest**, a graduate of the New England Baptist Hospital, Boston, died at Vancouver on October 9, 1956, in her 81st year. For many years Miss Forrest served as supervisor of the infectious diseases department at Vancouver General Hospital.

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**Frances King**, who graduated from Toronto General Hospital in 1936, died at Vancouver on August 18, 1956.

Following graduation, Miss King served with the Manitoba Department of Health and Welfare as staff nurse, then as supervisor. In 1945 she enrolled at Columbia University where she secured first her bachelor's then her master's degree, specializing in public health nursing education and administration. She remained in New York with the Community Service Society, serving as supervisor, consultant in mental health and, later, as educational director. She joined the faculty of the University of Western Ontario School of Nursing, in 1949, and was largely responsible for the establishment of the first postgraduate program in psychiatric nursing. In 1950 she headed the basic program of studies in public health nursing which post she filled until her death.

Active in the affairs of both the Canadian Public Health and the Mental Health Associations, Miss King served the London community through the local Mental Health Association, as a member of the Council for Social Planning, and on the executive of

the Community Chest. Many public health nurses who had the privilege of studying under her direction will realize most keenly the serious loss her untimely passing has occasioned.

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**Mary S. MacDonald**, a graduate of Charlottetown Hospital, died at Montreal on September 2, 1956, following a brief illness. Miss MacDonald served with the R.C.A.M.C., during World War II, on the hospital ship, *Lady Nelson* and on hospital trains across Canada. Following demobilization she worked in Halifax and more recently at Queen Mary Veterans Hospital, Montreal.

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**Margaret Isobella MacIntosh**, who graduated from Royal Victoria Hospital, Montreal, in 1902, died at Montreal on September 27, 1956, aged 86. Prior to enlisting in the C.A.M.C. in World War I, Miss MacIntosh served at R.V.H. as night superintendent, later as supervisor of the outpatient department. Returning to R.V.H. following her war-time experiences, she took charge of the nurses' home until her retirement in 1949.

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**Susanna McCauley**, who graduated from Hamilton General Hospital in 1920, died there on September 6, 1956 at the age of 77.

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**Ethel Patricia (Sunderland) Pinder**, who graduated from Regina General Hospital in 1938, was killed in an automobile collision near Virden, Man., on October 4, 1956. Mrs. Pinder served on the R.G.H. staff until she joined the R.C.A.M.C. She served overseas until her marriage in 1943.

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**Elizabeth Reid**, a graduate of Christ Hospital, Jersey City, N.J., died on September 4, 1956, following a heart attack. Miss Reid had worked for many years in Vermont before returning to her home in Ayr, Ont.

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**Sister St. Bertha**, who graduated from Misericordia Hospital, Winnipeg, in 1927, died at Montreal on August 29, 1956 following a lengthy illness. She had served as director of nurses and later as superior at Misericordia Hospital.

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**Roberta Hope Turnbull**, who graduated from Regina General Hospital in 1935, died at Hastings, England, on September 5, 1956. Miss Turnbull had nursed at hospitals in Cumberland and Vancouver, B.C. and at

Mountain Sanatorium, Hamilton, Ont., before going to England.

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**Marguerite Wharrey**, who graduated from the Ottawa Civic Hospital in 1930, died on March 18, 1956 after a brief illness.

Miss Wharrey had engaged in private nursing.

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**Caroline Agnes (Ruthven) Wyand**, who graduated from Lady Stanley Institute, Ottawa, in 1908, died on August 18, 1956.

## Graduation Pictures



Miss Bietsch, director of nursing, with Mrs. E. Richards, Alumnae president and Mrs. W. C. Campbell, past president.

The Multiplex swinging wing-panel presented to the Medicine Hat General Hospital School of Nursing by the alumnae association will be used to house pictures of graduating classes. Photographs are mounted on a royal blue background with a gold border (the school colors). Each panel has a mica covering. There are 10 swing panels — 20 panels for mounting purposes — with enough space to mount the graduation pictures of the next 50 years.

The hospital building was completed and

opened in 1890. The school of nursing has been in operation since 1894 with the first class of four members graduating in 1896. The earliest photograph available was that of the 1903 graduates. A total of 492 nurses has graduated since that first ceremony 60 years ago. The album presently contains the pictorial record of 32 graduation groups.

"To perpetuate the memory of those who have gone before and to promote their ideals in those who follow."

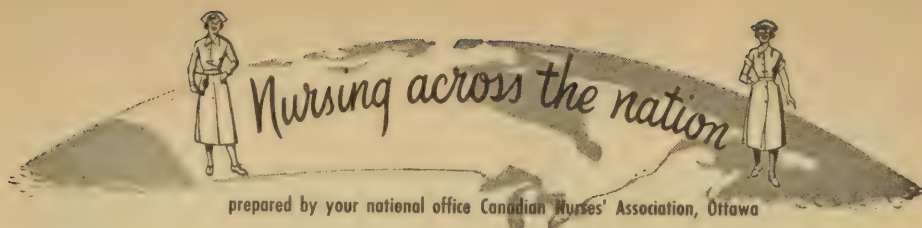
ELIZABETH BIETSCH

Without a knowledge of, and a feeling for the past, we cannot build as we should in the present and for the future. We, as Canadians, have been rather neglectful of this truth in years gone by. We have allowed ancient buildings to disintegrate; we have

permitted historic documents to disappear and we have, I think, done less than we should have to remind our people of the achievements of our forebears, from whose courage and labor we so greatly profit.

— RIGHT HON. VINCENT MASSEY





## ***I.C.N. Congress***

Rome, May 27 to June 1, 1957, will see some 235 Canadian nurses attending the 11th Quadrennial Congress of the International Council of Nurses. Since early in 1956 requests for applications have been received from CNA members. Indications are that we will use our full Canadian quota of 235.

The tentative program, which has been distributed to all applicants, gives the following details:

### ***Congress Theme — Responsibility***

Meetings of the Grand Council will be held the first days of the Congress. (The Council is the voting body of the I.C.N. and consists of members of the Board of Directors together with four accredited delegates from each active member Association.)

The last three days will be devoted to papers and discussion of: Responsibility for the Selection of Nurses; Responsibility for the Education of Nurses; Responsibility for Nursing Administration.

We are happy to announce that Miss Helen Carpenter, assistant professor, University of Toronto School of Nursing, and Second Vice-president, CNA, will represent Canada as she presents a paper under the general topic: "The Role of the Nurse in the Total Health Program." Other papers to be presented on this theme will be given by speakers from Sweden and Italy.

Representing the CNA will be our President, Miss Trenna Hunter, and General Secretary, Miss M. Pearl Stiver.

### ***Committee Manual***

For the guidance of the chairmen and members of national committees a Committee Manual has recently been distributed. Prepared in National Office, this Manual discusses the struc-

ture of committees — national, special and subcommittees, their functions, membership, preparation of minutes and reports.

Information about travel arrangements, assistance available from National Office and the Bylaws governing the functions of our five national committees are also included.

While it is designed to explain and facilitate the work of our own Association, the Manual may also be helpful to other groups who function under a somewhat similar organization.

To facilitate committee activities, channeling of information and accurate recording, an outlined procedure is necessary. A manual, however, will not guarantee successful action, for this is dependent on the progressive and thoughtful work carried on by each committee member. May we wish our 75 CNA committee members success in this biennium.

### ***A.N.P.Q. Curriculum Talks***

During the past several years, the Curriculum Committee (English-speaking) of the A.N.P.Q. has been working on a revision of its curriculum for schools of nursing. The result, still incomplete, is a distinct departure from the traditional. For three days in September, directors of nursing and instructors from the schools of nursing were brought together to discuss the work already accomplished and to prepare statements of guiding principles for selection of content in teaching clinical nursing. Because of lively and lengthy discussion of the general concept of disease which must be understood by the nurse before she can give intelligent care, it was not possible to develop content. The Committee hopes that, by further study and discussion, the background of knowledge needed by the nurse will be analyzed and much irrelevant material eliminated.

## **Home Care,**

During the past 10 years, the increasing number of persons requiring long-term care, the high costs of institutional care and of hospital construction and a growing awareness of the adverse effects of prolonged institutionalization have stimulated a keen interest in the provision of care to patients at home.

Hospital Home Care Plans originated with the Montefiore Hospital New York City, as a measure to deal with the problem of an inadequate number of hospital beds and care for the large number of chronically ill.

The Herbert Reddy Memorial Hospital, Montreal, instituted a Home Care Plan in 1950 in cooperation with the V.O.N. The patient leaves the hospital at an earlier date than usual and spends the period before complete convalescence at home. Internes visit the patients under the direction of their own doctors and make reports as if the patient were still in hospital. The nursing service is carried out entirely by the Victorian Order of Nurses. The visiting nurse reports to the Home Care Section of the hospital so that complete records are available. As far as the patient is concerned, the plan has the double advantage of an early return to home atmosphere and conditions and a substantial lowering of the total cost of illness.

1 U.S. Dept. of Health, Education & Welfare "A Study of Selected Home Care Programs" Public Health Monograph No. 35, Washington, D.C.

## **Adult Education**

Who should be more interested in adult education than nurses? Every nurse is a health educator and is called upon to teach people of all ages during the course of her work. Because of this, your Canadian Nurses' Association is a member of the Canadian Association for Adult Education and participated in the meeting of the C.A.A.E. Joint Planning Commission in Ottawa on November 23. Through its relationship with organizations such as the C.A.A.E., the CNA is better able to interpret nursing to the public and in turn to profit from the experiences of other similar groups.

If anyone is interested in becoming an individual member of the C.A.A.E., the address is 113 St. George Street, Toronto, Ontario.

## **You Are What You Eat,**

Undernourishment in Canadian families is a health problem found at all income levels. This is due largely to ignorance of food values and indifference to the importance of food to health.

Nurses, because of their direct contact with people in homes, in hospitals, and at work, are in a key position to do some important health teaching with regard to nutrition. The personal approach is much more effective than mere printed words.

However, there are some excellent printed materials available from various sources which will be very helpful to the nurse in teaching "what to eat for health."

A mimeographed list of many of these materials, available from various sources, may be obtained from CNA. A loan folder, containing copies of the materials is also available on request.

2 Pett, L.B., "Nurses and Nutrition"

*The Canadian Nurse* September, 1950.

46:9:735.

## **What's New from CNA**

*A.B.C. of CNA* — a mimeographed leaflet giving up to date information about our membership — by number and by age, employment of nurses, composition of our executive and committees, and a list of associations on whose boards we have representation.

*CNA Publications* — another leaflet listing all publications now available from National Office.

These are available on request from CNA, 270 Laurier Avenue West, Ottawa.

## **New Developments**

Last February, Miss Gladys Sharpe, Past President of the CNA addressed the Presidents' Conference of the National Council of Women on the topic "Home Care Plans." As a result of this, the Health Committees of the Local Councils will this year be investigating the possibility of Home Care

**KNOX**

## Protein Previews



### New Booklet Presents Latest Facts on Feeding the Sick



Nurses often must devote much time to describing good nutritional practices.

"Meal Planning for the Sick and Convalescent" relieves you of the need for repeating over and over again essential dietary facts. This new Knox booklet presents the latest nutritional applications of proteins, vitamins and minerals, suggests ways to stimulate appetite and describes diets from clear liquid to full convalescent. It offers the homemaker for the first time detailed daily suggested menus for each type of diet, plus 14 pages of tested nourishing recipes.

If you would like copies of this new timesaving Knox booklet, use the coupon below.

Knox Gelatine (Canada) Limited  
Professional Service Department CD-24  
140 St. Paul St. West, Montreal, Quebec

Please send me ..... copies of  
the new Knox "Sick and Convalescent"  
booklet.

YOUR NAME AND ADDRESS



Plans in localities across Canada.

A new committee has recently been set up under the National Nursing

Committee of the Canadian Red Cross Society to proceed with a study of Home Care in Canada.

## Annual Meeting in Prince Edward Island

THE 35th annual meeting of the Association of Nurses of P.E.I. was held in September with an attendance of 82 members and 6 guests. Reverend John A. Sullivan pronounced the invocation at the opening ceremony, while greetings from Charlottetown were extended by City Councillor F. G. O'Neill and from the province by Dr. O. H. Curtis, Deputy Minister of Health.

In her address, the president, Sister Mary Irene, looked to the needs of nursing service and nursing education on "The Road Ahead." Advances in medical science and population increases make certain a continued and increasing demand for nursing services. "It is dangerous to assume that the upsurge in demand for health services will be accompanied by an upswing in interest in the health professions." The challenge and satisfactions of nursing must still be interpreted to prospective candidates to this profession. Schools of nursing must assume the responsibility of assuring adequate education of the best quality for the expected increased enrolment. This is dependent upon the availability of good teachers. Graduate nurses, in view of this need for instructors, supervisors and head nurses, should make use of any opportunity for postgraduate study. "It is likewise the responsibility of the hospital administration . . . to provide well prepared key personnel and to establish a continuing educational program for these employees."

A highlight of the meeting was the presentation of the nursing service dramatization prepared by Miss F. Lillian Campion, Nursing Service secretary with C.N.A. —

"Toward Better Nursing." Head nurses, supervisors and staff nurses from the local hospitals and health services participated. Of equal interest was a panel discussion on accreditation centred about the questions:

1. What is on the record regarding accreditation in Canada and the United States?

2. What was determined at the Biennial Convention regarding a program of evaluation and accreditation of schools of nursing in Canada?

3. What are our responsibilities as an association regarding the evaluation program, the pilot study and the accreditation of schools of nursing here in Prince Edward Island?

The following officers were elected: Pres., Miss Ruth I. Ross, 57 Orlebar St., Charlottetown; 1st Vice-pres., Mrs. Vera MacDonald, King's County Hospital, Montague; 2nd Vice-pres., Miss Katherine MacLennan, Provincial Sanatorium, Charlottetown; Hon.-Sec., Mrs. Don Wonnacott, P.E.I. Hospital, Charlottetown; Hon.-Treas., Mrs. John Cameron, Summerside; Chairmen of Committees; Nursing Education, Miss Bernice Rowland, Charlottetown; Nursing Service, Sister Mary Patricia, Charlottetown Hospital; Public Relations, Sister Mary David, Charlottetown Hospital; Legislation & By-Laws, Miss Verna Darrach, Charlottetown; Finance, Mrs. Lois MacDonald, P.E.I. Hospital, Charlottetown.

HELEN L. BOLGER R.N.  
*Executive Secretary*

ASSOCIATION OF NURSES  
OF PRINCE EDWARD ISLAND

## Unknown Soldiers

Two more unknown American service men will be entombed in Arlington National Cemetery beside the Unknown Soldier of World War I.

A bill signed by President Eisenhower

\* \* \*

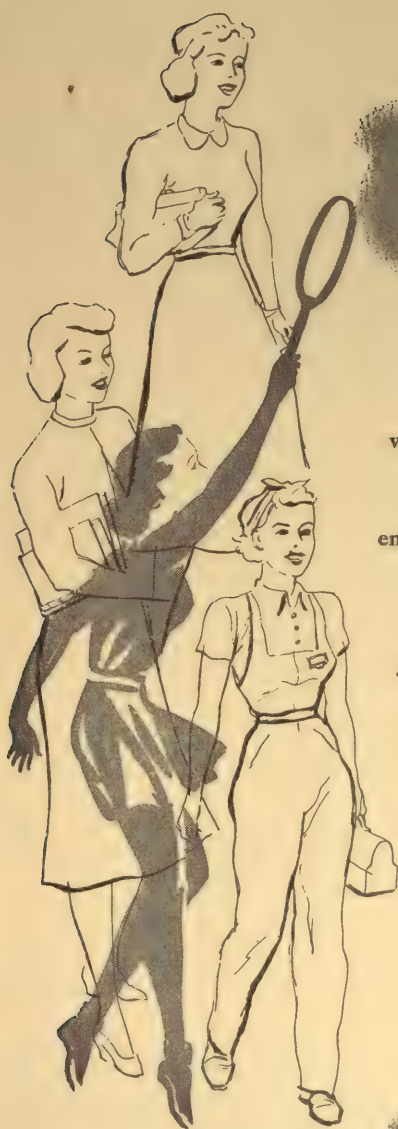
A man never knows what he can do until he tries to undo what he has done.

— FRANCES RODMAN

provides for the entombment on Memorial Day, May 30, 1958, of an unknown member of the armed forces who fell in World War II and an unknown soldier of the Korean conflict.

\* \* \*

One hundred mistakes will give you an education — if you have learned something from each one of them.



*no need to be*

# A W O L

Absent With Out Logic

By using TAMPAX intravaginal tampons, women in all walks of life usually find they can pursue their normal activities without interruption. The greater comfort, convenience, and safety of this improved method of menstrual hygiene has won the enthusiastic approval of nurses everywhere.

Physicians too have found it highly satisfactory. The three TAMPAX absorbencies—Regular, Super, and Junior—provide individualized protection to meet varied absorption requirements.

**COMFORTABLE** — physically and psychologically

**CONVENIENT** — easy to use, with individual applicators

**SAFE** — eliminates odor and irritation

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# TAMPAX

*the intravaginal menstrual guard  
of choice*

Canadian Tampax Corporation Limited  
Brampton, Ontario.

Shall appreciate samples.

R.N. \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

# Le Nursing à travers le pays

## Congrès du Conseil International des Infirmières

Rome, du 27 mai au 1er juin 1957, recevra les 235 infirmières canadiennes qui iront participer au 11ième Congrès Quadriennal du C.I.I. Dès le début de 1956, les infirmières commençaient à s'inscrire pour ce congrès ce qui pouvait déjà laisser prévoir que le contingent canadien de 235 serait au complet.

Le programme, sujet à revision, a été remis à toutes les infirmières qui ont demandé d'être inscrites pour le congrès et en voici les grandes lignes :

### Thème du Congrès: Responsabilité.

Assemblée du Grand Conseil le premier jour du Congrès (le conseil est formé des membres ayant droit de vote, les membres du Bureau des Directeurs et quatre déléguées de chaque Association membre actif).

Les trois derniers jours seront employés à la présentation de travaux et à des discussions sur les sujets suivants: Responsabilité dans le choix des étudiantes-infirmières; Responsabilité dans la formation de l'infirmière; Responsabilité dans l'administration d'un service de nursing.

Il nous fait plaisir d'annoncer que Mlle Helen Carpenter, professeur adjoint à l'Ecole d'Infirmières de l'Université de Toronto et deuxième vice-présidente de l'Association des Infirmières Canadiennes, représentera le Canada en présentant un travail sous le titre général: "Le rôle de l'infirmière dans l'ensemble du programme sanitaire." D'autres travaux seront présentés sur le même sujet par des personnes venant de Suède et d'Italie.

Les représentantes de l'A.I.C. seront notre présidente, Mlle T. Hunter et notre secrétaire-générale, Mlle P. Stiver.

## Le Manuel des Comités

Afin de guider les convocatrices et les membres des comités nationaux, un manuel a récemment été distribué. Préparé au secrétariat national, le manuel des comités présente la structure des comités nationaux et spéciaux ainsi que des sous-comités, leurs fonctions, leurs membres, la préparation des procès-verbaux et des rapports.

En plus, on y trouve des renseignements concernant les voyages, l'aide que peut nous apporter le secrétariat national, ainsi que les règlements des cinq comités nationaux.

Ce manuel a été préparé en vue d'expliquer et de faciliter le travail de notre association mais il peut aussi être utile à d'autres groupes dont l'organisation et le fonctionnement sont semblables aux nôtres.

Pour faciliter le travail des comités, canaliser les renseignements et compiler les rapports, un guide est nécessaire. Un manuel, cependant, n'est pas à lui seul une garantie de succès qui ne sera assuré que par le travail consciencieux de chacun des membres des comités. Nous souhaitons aux 75 membres des comités de l'A.I.C. du succès pour la présente période biennale.

## Programme d'Etudes de l'A.I.P.Q.

Ces dernières années, les comités du programme d'études de l'A.I.P.Q. français et anglais, ont travaillé à la revision du programme d'études à l'usage des écoles d'infirmières de cette province. En septembre, les directrices et les institutrices des écoles d'expression anglaise se sont réunies pendant trois jours pour examiner le travail déjà accompli et préparer une rédaction des principes susceptibles de déterminer le choix du programme clinique. Le résultat de cette conférence bien qu'encore incomplet laisse entrevoir qu'on semble s'éloigner de la tradition. Par suite de discussions longues et animées sur les connaissances générales que doit posséder l'étudiante avant de pouvoir donner des soins intelligents, il fut impossible de déterminer la matière du programme. Le Comité espère que de futures études et discussions permettront de déterminer les connaissances de base nécessaires à l'infirmière et d'éliminer du programme tout ce qui est inutile.

Le groupe français a fait en octobre la revision d'une partie du programme d'études mis à l'essai il y a déjà deux ans. Tenant compte des commentaires apportés par les diverses institutions, toutes les matières sont revisées à tour de rôle. Des experts, consultés au cours des séances d'études, ont aidé à l'élaboration d'un programme répondant aux besoins de notre temps.

## Soins à domicile (1)

Depuis dix ans, on a constaté un intérêt croissant en faveur du soin des malades à domicile. Le grand nombre de personnes ayant besoin de soins prolongés, le coût





## ANSWERS TO YOUR QUESTIONS ABOUT

# ACHROMYCIN

Tetracycline Lederle

**ACHROMYCIN** is a true broad-spectrum antibiotic, effective against a wide variety of infections including those caused by Gram-positive and Gram-negative bacteria, rickettsiae, and certain viruses and protozoa.

It is rapidly absorbed and promptly produces high blood levels, thereby controlling infection quickly.

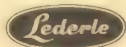
It is well tolerated by patients of every age, and the incidence of side reactions is negligible.

It is available in 21 dosage forms; the doctor can choose the one form best suited to the patient's needs.

Every gram of ACHROMYCIN is made in Lederle's own laboratory, and it is available only under the Lederle label—the doctor's assurance of highest quality.

Because of these important advantages, ACHROMYCIN is the most widely prescribed of all broad-spectrum antibiotics.

*If you should like more information about this or any other Lederle product, speak to the Lederle representative.*



LEDERLE LABORATORIES DIVISION  
NORTH AMERICAN Cyanamid LIMITED  
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élevé de l'hospitalisation et de la construction d'hôpitaux, le fait que l'on semble de plus en plus prendre conscience des effets préjudiciables que peut avoir un séjour prolongé dans les institutions ont contribué à accroître cet intérêt.

Les plans de soins "hospitaliers" à domicile ont été inaugurés par le Montifiore Hospital, à New York, comme moyen de résoudre le problème de l'insuffisance du nombre de lits d'hôpitaux et de prendre soin des malades chroniques.

A Montréal, le Herbert Reddy Memorial Hospital institua en 1950 un plan de soins à domicile en collaboration avec le Victorian Order of Nurses. Le malade quitte l'hôpital plus tôt et passe à son foyer la période qui précède la complète convalescence. Les internes de l'hôpital visitent les malades sous la direction du médecin traitant à qui ils font rapport tout comme si le malade était encore à l'hôpital. Les soins sont donnés par les infirmières du V.O.N. L'infirmière fait ses rapports au département des soins à domicile de l'hôpital afin qu'un dossier complet soit à la disposition du médecin. Au point de vue du malade, ce plan a deux avantages: un retour précoce au foyer dans un milieu familial et une diminution marquée du coût de la maladie.

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(1) U.S. Dept. of Health, Education & Welfare "A Study of Selected Home Care Programs" Public Health Monograph No. 35, Washington, D.C.

### *Initiatives*

En février dernier, Mlle G. Sharpe, ancienne présidente de l'A.I.C. adressait la parole aux présidentes réunies pour la conférence du "National Council of Women." Son sujet fut: "Les plans de soins à domicile." A la suite de cette conférence, les comités de santé des conseils régionaux se proposent d'étudier cette année la possibilité d'établir des plans de soins à domicile dans les différentes villes du Canada.

A la Croix-Rouge Canadienne, sous la direction du Comité National du service du Nursing, un comité fut formé pour étudier les plans de soins à domicile à travers le Canada.

### *Education des Adultes*

Qui peut s'intéresser davantage à l'éducation des adultes que l'infirmière? Chaque infirmière est un professeur de santé et elle est appelée de par sa fonction à enseigner à des personnes de tous âges, tout le long

de sa carrière. C'est pour cette raison que l'A.I.C. est membre de La Société Canadienne de l'Education des Adultes et participe à ses assemblées. Les relations de l'A.I.C. avec la Société lui fournissent maintes occasions de faire connaître les services d'infirmières ainsi que de tirer elle-même profit de l'expérience d'autres groupes.

Si quelqu'un est intéressé à devenir membre de la Société Canadienne de l'Education des Adultes, il peut s'adresser à 3425 rue St-Denis, Montréal.

*Dis-moi ce que tu manges  
je te dirai qui tu es!*

Une mauvaise alimentation est un problème que l'on rencontre dans presque toutes les familles canadiennes, quels qu'en soient les revenus. Il faut attribuer cette déficience à l'ignorance de la valeur des aliments et du rôle important qu'ils jouent dans la santé des individus.

Les infirmières, par leur contact direct avec les gens — au foyer, à l'hôpital ou au travail — sont dans une position des plus favorables pour enseigner la nutrition. Le contact personnel a beaucoup plus d'effet qu'une simple lecture.

Il existe cependant d'intéressants dépliants, brochures, etc. publiés par diverses organisations qui aideront l'infirmière à enseigner "ce qu'il faut manger pour être en santé."

Une liste de ces publications peut être obtenue de l'A.I.C. Une enveloppe contenant un groupe de ces diverses publications sera prêtée à qui en fera la demande.

### *Quelles nouvelles à l'A.I.C.?*

*L'A.B.C. de l'A.I.C.*! C'est un feuillet miméographié donnant des renseignements de la dernière heure sur les membres, l'emploi des infirmières, la composition du comité exécutif et des comités nationaux et la liste des associations au bureau de direction desquelles l'A.I.C. est représentée.

*Publications de l'A.I.C.* Un autre feuillet donnant la liste de toutes les publications que l'on peut se procurer au secrétariat national.

Dans les deux cas, s'adresser à L'Association des Infirmières Canadiennes 270 ouest avenue Laurier, Ottawa, Ont.

---

More than 100,000 displaced persons have been reunited with relatives since World War II through the efforts of the International Committee of the Red Cross, the Committee announced recently.



**"Infants fed meat under 2 months of age . . .  
improvement in physical growth."**

Jacobs & George in "Evaluation of Meat in the Infant Diet," *Pediatrics*, 10,463 (1952) report that there was an improvement in physical growth as determined by weight and height measurement in infants first fed meat under two months of age. The same group demonstrated an improvement in hemoglobin levels; the elimination of the physiologic drop in total protein levels of the serum, with a prompt sustained rise in values, the greater part of which was composed of the globulin fraction.

*Swift's produce eight kinds of Meats for Babies for variety and for special nutritional*

*benefits—beef, lamb, pork, veal, liver, heart, liver and bacon, strained chicken and Egg Yolks for Babies and Salmon Seafood. Also Chopped Meats for Juniors with a texture of sufficient coarseness to help children adapt easily and gradually to table foods.*

*Recommend with confidence Swift's Meats for Babies and for Juniors.*

**Meats for Babies**  
**SWIFT'S**  
most precious product



*To Serve Your Family Better*



**SWIFT CANADIAN CO., LIMITED.**



# Book Reviews

**Truth About Cancer**, by Charles S. Cameron, M.D., Medical and Scientific Director, American Cancer Society. 257 pages. Prentice-Hall, Inc. Publishers, 70 Fifth Avenue, N.Y., 1956. Price \$4.95.

*Reviewed by Dr. H. S. Morton, Central Tumor Registry, Royal Victoria Hospital, Montreal.*

The "Truth About Cancer" is a dramatic and an accurate description of the story of cancer at the present time. With clear and concise definitions, the picture is vividly presented.

The first part of the book consists of a general review of the whole situation and is excellent, particularly the chapters on cause, misconceptions, diagnosis, treatment, quacks and research. The account of incidence is naturally weak because on this continent so little is known about incidence. This is one of the greatest weaknesses in the present attack on this group of diseases.

The second part of the book called "A Closer Look at the Different Anatomical Sites" gives a fairly detailed description of these in simple terms.

This volume, sponsored by the American Cancer Society and written by its medical and scientific director, is an able straightforward attack on this major problem.

**Aids to Surgical Nursing**, by Katherine F. Armstrong, S.R.N., S.C.M., D.N. (Lond.). 432 pages. The Macmillan Company of Canada Limited, 70 Bond Street, Toronto 2, Ont. 5th Ed. 1954. Price \$1.00. *Review by Miss Anne Fallis, Calgary General Hospital, Calgary, Alta.*

This is one of "The Nurses' Aid Series," small handbooks that can be easily carried for ready reference, at a price any nurse can afford.

It contains such information in relation to general surgery as: the basic knowledge on which surgery is based, complications of, preparation for and detail concerning specific surgical conditions. Reference is made to the newer methods in heart operations and in sympathectomy. It does not include the surgical treatment of varicose veins. Approximately 50 pages are devoted to fractures which seems a rather high proportion in a book of this size. It does not contain details of nursing procedures, gynecological surgery or surgery of the eye, ear, nose and throat which are in separate volumes.

It is clearly and concisely written, often in point form. As this is a British book, there are differences in the use of terms, i.e. fomentations for sterile compresses, and in the names of drugs in use. For this reason the graduate or senior student will find it a useful reference, but not the junior student who has not learned to make adaptations.

**Principles and Techniques of Psychiatric Nursing**, by Madelene Elliott Ingram. R.N. 529 pages. W. B. Saunders Company, Philadelphia and London. 4th ed. 1955. Price \$4.75.

*Reviewed by Sister Thomas Joseph, Halifax Infirmary, Halifax, N.S.*

This revised textbook should be warmly received by those seeking a means of introducing the student to the "how" and "why" of psychiatric nursing. The author is to be commended for placing a much needed emphasis on the student "relating the patient to the environment rather than the reverse."

The dynamic approach to the clinical situation should aid the student to assume her role as a teacher and leader, as well as to acquire the technical skill and understanding required of a good psychiatric nurse.

The illustrative figures throughout the book, the various case histories and problem-solving situations followed by the student's critical appraisal will be of incalculable value to the teacher.

Exception might be taken to the interpretation of various religious viewpoints expressed in Unit I, which gives a brief but concise history of nursing.

One concludes the reading of this text in complete accord with the author's opinion that knowledge of advanced theory in itself does not make an "advanced" psychiatric nurse.

\* \* \*

In a free democracy it is essential that each man have an understanding of himself and of his job in its context. He must know enough about his society to act as an intelligent citizen in it; and he should be familiar enough with its culture to be able to make intelligent individual choices in life.

— OSCAR HANDLIN

\* \* \*

The greatest thing in this world is not so much where we stand, as in what direction we are moving. — OLIVER W. HOLMES

Confirmed again clinically<sup>1</sup>  
the remarkable  
**safety-efficiency**  
record in relief of  
**constipation**  
and **teething**  
gastrointestinal upset and malaise  
**Baby's Own Tablets**

Extensive newly completed studies verify the outstanding safety record and the efficiency of BABY'S OWN TABLETS. Patients ranged in age from 2 months to 24 months.

One large group of infants suffered constipation, another group intestinal disturbances and malaise, coincident with teething.

The result from the studies were as follows . . .

**ALL CONSTIPATED BABIES** were relieved with complete easing of straining at stool, gas discomfort, restlessness and crankiness.

**ALL TEETHING BABIES** suffering concomitant gastrointestinal disturbances and malaise were relieved except one. Disturbed sleep, restlessness, crankiness were relieved as well as anorexia and

constipation when present.

**EMINENTLY SAFE** — "Throughout the study . . . in no instance was there any untoward reaction; no cutaneous eruptions or other allergic manifestations, no petechiae, no rise in rectal temperature, no alteration in cardiac and respiratory function, no vomiting or diarrhea, no oliguria, no albuminuria. No significant changes were observed in weight, growth, development or hemoglobin before and after the period of medication."

Pleasant, convenient BABY'S OWN TABLETS provide Phenolphthalein  $\frac{3}{16}$  grain, mildly buffered with Precipitated Calcium Carbonate  $\frac{1}{2}$  grain, and Powdered Sugar q.s.

Send for a sample supply and literature citing references.<sup>1-12</sup>

**G. T. FULFORD CO., LIMITED, Brockville, Ontario**

# Sélection

## Les préjugés

Avant de faire un stage en psychiatrie, j'avais, comme tout le monde ou à peu près, des préjugés concernant les maladies mentales. Je croyais lorsqu'on amenait quelqu'un dans un hôpital psychiatrique, que c'était nécessairement un grand agité. J'ai, par les nombreux cours que nous avons suivis, beaucoup appris au sujet de maladies et de techniques inconnues auparavant. Les malades que nous avons soignés dans les départements nous ont permis une application pratique de ces cours.

Si une personne de mes proches tombait malade et était hospitalisée dans une de ces institutions, mes parents seraient bien peinés et la prendraient en pitié mais je crois qu'ils essaieraient de cacher autant que possible son état à l'entourage.

La cerveau étant la partie noble du corps de l'homme, son atteinte paraît plus grave. Personne ne veut avouer qu'il n'a pas la tête bien solide et c'est probablement pour cela qu'il est difficile d'abolir les préjugés vis-à-vis ces maladies.

Souvent les parents d'un malade s'objectent lorsqu'il est nécessaire d'avoir recours à un psychiatre; alors, il faut leur démontrer par plusieurs exemples que les maladies mentales, prises à point, guérissent. Voyant ainsi la possibilité d'une guérison, ils accepteront peut-être plus volontiers l'hospitalisation du malade. Il faut qu'ils comprennent qu'il n'est pas plus honteux d'être atteint d'une maladie mentale que d'être cardiaque ou tuberculeux.

Les maladies mentales guérissent si on les prend au début; elles restent stables ou empirent lorsqu'on les soigne trop tard. Grâce à tous les traitements que l'on trouve dans un hôpital psychiatrique: insuline, électrochoc, psycho-thérapie, médication, les malades s'améliorent nécessairement. Toutefois, il est bon que le patient change de milieu lorsqu'il sort de l'hôpital car le milieu influe énormément sur toute personne. Prenons un cardiaque hospitalisé à la suite d'une crise, s'il retourne dans la même vie agitée, il pourrait bien faire une nouvelle crise qui lui sera peut-être fatale.

Le fait d'avoir été hospitalisé ne constitue pas, en soi, une tare; cela peut arriver à des gens de tous les milieux et de toute profession. J'accepterais bien volontiers de travailler avec un ancien malade mental mais je prendrais quand même quelques précautions élémentaires. En apprenant à la suite de quels événements la maladie a débuté, je m'efforcerais d'éviter à cet ancien malade les situations susceptibles de l'affecter.

Mon stage m'a été bien profitable, car j'ai pu observer tous les traitements qui se donnent et les résultats obtenus. Dans une période d'un mois et demi, j'ai déjà vu plusieurs de mes patients qui sont retournés chez eux guéris. N'est-ce pas là un encouragement pour les malades et une satisfaction pour ceux qui leur donnent des soins?

Extrait de *Sentinelle*, journal des étudiantes-infirmières de l'Hôpital St-Jean, Saint-Jean, P.Q.

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In muscular dystrophy, extensive studies have detected an error in protein metabolism. It has been learned that oxyproteic acid is not metabolized properly in patients. Researchers are now trying to determine if this is a cause or an effect of the disease. — *Scope Weekly*

## News Notes

### ALBERTA

#### DISTRICT 2

##### CAMROSE

Mrs. Hardnut, chapter delegate to the

CNA convention in Winnipeg gave a very interesting and comprehensive report at the well attended September meeting. To augment the Bursary Fund the annual Nightingale Dance was scheduled for the end of October





## COCA-COLA PUTS YOU AT YOUR SPARKLING BEST

Delicious flavour, and wholesome refreshment have made Coca-Cola a favour everywhere.



**COCA-COLA LTD.**

### PONOKA

A well attended meeting on September 19 opened the fall activities when Mrs. E. Coombs was elected the new president of the district association. An interesting program was provided by one of the members who recently visited Denmark and took many pictures. The very pleasant evening ended on the right note for the hunting season! Roast duck with all the delicious trimmings was served.

### DISTRICT 3

#### BANIFF

Attendance at the Baby Clinic, sponsored by the Chapter, has grown to such an extent that larger accommodation in the school auditorium has been secured.

At a small tea at Mrs. Gourlay's home the bursary awarded to Zona Paris of Baniff was presented together with a lovely book of mountain paintings. Zona is now enjoying her new life at the University Hospital, Edmonton.

An "Autumn Ball" sponsored by the Federal Employees' Recreational Society was well attended. The proceeds were given to assist the chapter's Children's ward project.

Miss I Krandel, public health nurse with the Morley Indian Reserve gave a lively and

informative talk on the trials and satisfactions of working among the Indians.

### CALGARY

Forty members participated in the supper meeting which marked the annual district gathering. A report of the Biennial convention was given by L. Bibby. The slate of officers for the coming year was elected.

### DISTRICT 4

#### PROVOST

A film depicting the surgical repair of patent ductus arteriosus highlighted the September chapter meeting. Eleven members were in attendance.

### DISTRICT 6

#### RED DEER

D. Hilsabeck of Clive was the successful candidate for the \$300 chapter scholarship given to assist a girl to obtain her professional training. A social gathering and "pretaining" shower was held at the home of Lady Stonehouse as part of the presentation ceremony.

# Complete Carbohydrates

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## DISTRICT 7

### EDMONTON

The district association approved affiliation with the Local Council of Women, at its business meeting in October. The program featured a panel discussion on student nurse recruitment under the title "Interesting Nurses." Miss J. Clark was chairman with Shirley Stinson, Mrs. Peggy Marko and Floreen Sydorchuk, a third year student, participating.

### STONY PLAIN

Mr. A. Miller, legal adviser to the A.A. R.N. spoke on the Legal Aspects of Nursing at a recent chapter meeting. An interesting period of discussion followed the address. Mr. A. Yuhem will conduct a course in first aid.

## DISTRICT 8

### PINCHER CREEK

Chapter members assisted with a tag day for St. John's Ambulance early in October. Plans are underway for a gala Christmas party.

## BRITISH COLUMBIA

### CARIBOO DISTRICT

Mrs. Winifred Warner of Prince George was elected president of the district at the annual meeting held in Quesnel the end of September. Miss A. Wright, provincial executive secretary, was guest speaker and described her trip to Denmark last spring, illustrating her talk with many interesting slides she had taken. Mrs. Len Taylor was hostess for a coffee party following the meeting.

### QUESNEL

At the October chapter meeting a letter of appreciation was read from Joy Leake of Nazko who was winner of this year's Bursary award. She entered the school of nursing of Vancouver General Hospital in September. Bursary winners will be remembered, henceforth, with a small financial gift at Easter during their second and third years in training.

### CHILLIWACK

Forty-two members attended the annual dinner meeting of the chapter. The guest speaker was Miss Trenna Hunter, president

of the CNA. A gift was presented to her on behalf of the members in token of their appreciation. A doll drawing is to be held this month with proceeds being used for furnishings for a ward in the new hospital wing. A jewellery and clothing drive is to be held for the Crease Clinic and Provincial Mental Hospital, Essondale.

## PENTICTON

At the September meeting, with Mrs. Innes Brown presiding, Mrs. Verna Crittenden presented an interesting report of the 28th Biennial Convention and showed pictures she had taken on her trip. Mrs. Crittenden was named convener of the special committee to arrange for the annual meeting of Kamloops-Okanagan District that will be held here.

At the October meeting, two surgical films — Halstead operation for carcinoma of the breast and one-stage total colectomy for ulcerative colitis evoked great interest.

## VANCOUVER

### *St. Paul's Hospital*

A homecoming was held in mid-October with members of the classes of '21 and '22 as honored guests. A short program preceded an evening of visiting and renewing acquaintances. In November a fashion show and sale of work proved successful, with a cocktail dress being presented to the winner of the door prize.

C. Guimont and S. Warren who have been nursing with the Suez Contractors Service have returned to England due to the political situation. L. Belecky has joined the staff of Woodward's Stores. D. (Boden) Coombes has gone to Bedfordshire, England. Sister Charles and Sister Elie celebrated their 50th anniversary as members of the sisterhood in August. Sister Denise Margaret is on the staff of the new hospital at McLellan, Alta

## MANITOBA

### HAMIOTA

Local nurses were hostesses at the first general meeting of District 2 early in October. Thirty-five members were in attendance with Mrs. Jean Fargey presiding. A group led by P. Long presented a series of reports from the 28th Biennial Convention. Miss M. Dunn, matron of the local hospital, conducted a tour of the building. At the November meeting which was held in the Hospital for Mental Diseases, Brandon. Miss Lillian Pettigrew addressed the members on "The Registered Nurses' Act and Bylaws."

## WINNIPEG

### *General Hospital*

The first meeting of the season for the alumnae association was held in the auditorium of the nurses' residence. To com



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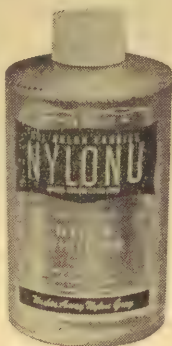
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memorate the Golden Jubilee of the association which occurs in 1957, Miss Ethel Johns was asked to write the history of the school. This book is almost ready to go to press. After 28 years with the hospital, fourteen of which were spent as superintendent, Dr. H. Coppinger has retired. A number of social events marked this occasion.

## NOVA SCOTIA

Miss Joan Palmer, who took her public health nursing at McGill University, joined the staff of the Department of Public Health in 1951. Miss Palmer remained on the staff as public health nurse in Shelburne until recently. She has been granted leave of absence to take a course in administration and supervision at McGill University.

Miss Margaret Masters, nursing consultant in the Child and Maternal Health Division for the Province of Nova Scotia resigned her position as of September 21 to accept a position at the Jewish General Hospital, Montreal, teaching student nurses.

Miss Mary MacSephney who took her basic public health at Dalhousie University 1953-54, and then worked on the staff of the Department of Public Health from the Tatamagouche district until July of this year, at which time she was transferred to the Truro office, has been granted a year's leave of absence to take a course in administration and supervision at the University of Toronto.

## ONTARIO

### DISTRICT 5

#### *Toronto Western Hospital*

The fall general meeting of the Alumnae Association was held early in October. The guest speaker was Miss D. McGeachy, who gave an interesting account of her work in the newly acquired Speech Clinic.

The Class of 1931 held their 25th Anniversary reunion dinner at the hospital early in June. Guests of honor at the dinner were Miss Beatrice Ellis and many of the class teachers and supervisors. Following a tour of the hospital, the new educational building and the Archives, the class attended a party at the Seaway Hotel to complete a most enjoyable weekend.

Miss Margaret McKenzie was recently on six weeks' leave of absence from her position with the World Health Organization, near Calcutta, India, where she is enjoying her work in public health. Sona Canara has been appointed as nursing superintendent of the United Church of Canada Hospital, Mandleshwar, India. Jean Craig is working at the Leslie Hospital in Honolulu. Betty McKay is attending McGill University. Miss Kathleen Peebles and Miss W. Bartolices are busy at University of Toronto. Florence Inch has recently been appointed head nurse on 5 East, after having completed a post-graduate course in obstetrics at the Chicago Lying-in Hospital. D. Hall has recently joined the staff as an instructor in the surgical department.



## KINGSTON

*The Ontario Hospital*

Graduation exercises took place on September 21 when 16 nurses received their pins and diplomas. The guest speaker was Professor A. Edinborough, editor of *Whig-Standard*. The prize for Anatomy and Physiology, donated by the Nurses' Alumnae, is to be an annual award.

The graduating class were entertained by Dr. and Mrs. C. H. McCuaig, Dr. and Mrs. E. A. James, Dr. and Mrs. Henry Shaffer, Mrs. T. Ferguson, Ontario Hospital nursing office and supervisors. The Alumnae also entertained them at a dinner and presented each with a year's membership in the Association and a gift of a crystal vase.

Church service for the graduating class was held Sunday, September 16, at St. John's Anglican Church, conducted by Canon Minto Swan. The choir entertained following the service.

On September 28, 1956, the corner stone was laid by Hon. Wm. Nickle for the new 500-bed addition and administration building. Miss E. G. Smith, superintendent of nurses placed the documentary box in the corner-stone. It is expected that this new addition will be open in the Fall of 1957.

Miss Florence Latimer, assistant superintendent of nurses, attended the Biennial Convention in Winnipeg this year.

Several changes have taken place in the nursing staff: Miss A. Ladas is touring Europe and Miss L. Legge, B.N.Sc., is in charge of the affiliation program; Miss S. Potter, B.N.Sc., is our new science instructor and Mrs. M. Fooks our health instructor. Mrs. D. Ferguson and Miss H. Zarins entered Queen's University in September to take teaching and supervision.

## DISTRICT 8

## OTTAWA

*Civic Hospital*

The alumnae's annual tea and bazaar was held on November 2. A special feature was the "Post Office" table where unopened gift parcels were eagerly sought at 25 cents each.

A gift of opera glasses was presented to Effie McIlraith whose departure was marked at a tea in early May.

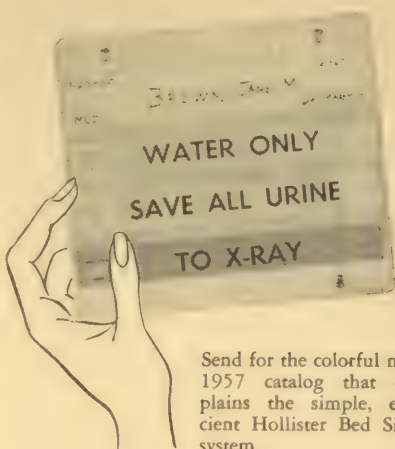
The fifth bursary-loan award was made to Irene Clarke, '54, who is majoring in public health nursing at the University of Western Ontario this year.

An alumnae chapter was formed in Toronto recently. Any O.C.H. graduates in that vicinity are asked to get in touch with Mrs. D. Piercey, 122 Norsemen St., Islington.

*General Hospital*

Members of the graduating class were

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guests of honor at a banquet held in September. Approximately 150 alumnae members and guests attended. Miss C. Casey, a graduate of 50 years ago, was presented with a scroll and life membership. The classes of '26, '31, and '46 took this opportunity to hold reunions. Mrs. O. Stewart convened arrangements for the dinner assisted by Mrs. A. Hobbs and Sister Madeleine of Jesus.

## PRINCE EDWARD ISLAND

### CHARLOTTETOWN

#### *Charlottetown Hospital*

In September, alumnae members observed the 25th anniversary of their association. Almost every class from 1923 to 1956 was represented at the banquet. An honored guest was Miss Mae King — a member of the first graduating class and the first president of the alumnae association. During the evening pictures of each graduating class were shown while Mrs. H. Murphy related in verse humorous anecdotes of training experiences. Later, alumnae members were joined by their husbands and friends for dancing. Approximately 100 religious and lay nurses shared the day's activities commemorating this occasion.

## QUEBEC

### DISTRICT 9

### QUEBEC CITY

#### *Jeffery Hale's Hospital*

J. Radley Walters is attending the School for Graduate Nurses, McGill University, enrolled in the teaching course in medical and surgical nursing. A. MacDonald is doing postgraduate study in obstetrics and gynecology in the Royal Victoria Montreal Maternity Hospital. S. Grey has joined the staff of the Polyclinic, New York City.

### DISTRICT 11

### MONTREAL

#### *The Montreal General Hospital*

All year we have been looking forward to celebrating our 50th anniversary which was deferred for one year at the request of the medical staff, so that our celebration would coincide with the medical staff reunion. The dates selected were September 20, 21 and 22, 1956 — three red-letter days in the history of our alumnae.

The air of expectancy and excitement reached its peak on the morning of September 20. The final preparations were completed so we were ready to enjoy our get-together.

September 20 dawned dull and misty to the great disappointment of our ardent alumnae and hospital staff but our prayers were answered and the weather cleared. By 9:00 a.m. the sun was shining and a huge



crowd had gathered in the main entrance of the hospital where each member registered. People assembled in constantly changing groups where news was exchanged and greetings extended. Members had come from all across Canada, from the Atlantic to the Pacific. Gradually the crowd sorted itself out to attend the tours, lectures and demonstrations.

At 3:30 p.m. slightly tired but still full of enthusiasm, the crowd arrived in Livingston Hall for tea. It was a great success. The home never looked nicer, decorated with a profusion of roses and autumn flowers. More than ever we realized we were members of one big family. The sentiment and feeling towards The Montreal General Hospital still lives today in the new buildings. It was demonstrated by the enthusiastic gathering that the spirit of the members makes an institution what it is. Bricks and mortar are insignificant. The feeling of pride at belonging to such a united group influenced most members to enter into conversation with whoever happened to come near. In short, it was a very gay and friendly tea party.

We had to bid hasty au revoirs to get ready for the dinner at the Windsor Hotel. Here, the increase over the numbers expected delayed proceedings for a while. It was welcomed; more visiting together could be done. It was during these chats that many private class parties were arranged. This increased the reunion's popularity.

The dinner was attended by 500 members. The highlight of the evening was the speech by Miss M. J. Denniston, director of nursing of Methodist Hospital and Blank Memorial Hospital in Des Moines, Iowa. Miss Denniston graduated from The Montreal General Hospital with the class of 1929. All the outstanding characters in the old General, (while she was there) from the highest to the lowest were included in her witty talk, to the delight of the audience. Then she passed along to the present day with our modern devices and philosophies. No one could have bridged the gap between the old and the new more effectively than Miss Denniston. When we sang Auld Lang Syne, it was a happy ending to a very full day.

Friday, the doctors' wives sponsored a luncheon and fashion show in the Mount Royal Hotel which was attended by a capacity crowd. Here again, one heard the greetings and gay conversation of friends meeting after many years of separation. This was a gala occasion enjoyed by everyone. On the same day in the afternoon the doctors' wives and nurses shared tea and reminiscences at the Museum of Fine Arts.

Saturday dawned with beautiful bright sunshine. The crowd had begun to thin out and it was with a feeling of nostalgia that we attended the football game at Molson's Stadium. Excitement kept our spirits up till the end of the game when we said goodbye to our friends.

Looking back on those three days, nothing could have done more to make our alumnae realize that the new building is really The Montreal General Hospital regardless of its situation and modern decor. The old feeling

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*Royal Victoria Hospital*

At the October meeting of the alumnae Mrs. Scrimger gave a description of her trip to England last June to attend the Victoria Cross Centenary Celebration. Miss Mary Warnock, who had attended the CNA convention in Winnipeg as the alumnae's representative, gave a report of the business conducted there.

Edith Green has completed her tour of duty with World Health Organization in Alexandria, Egypt, and has returned to Victoria, B.C. B. Locke and I. Rimstead



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are on the staff of King Edward VII Memorial Hospital in Bermuda.

**SASKATCHEWAN**

**PRINCE ALBERT**

The chapter meets on the first Monday of each month throughout the year excepting July and August. These meetings alternate between the Victoria Hospital, The Holy Family Hospital, and the Prince Albert Sanatorium. At the close of each meeting the staff of the hospital serves refreshments.

The project of the chapter is to supply cod liver oil to needy children of the city. To raise funds for this purpose we have been sponsoring an annual dance, conducting rummage sales and each member is expected to contribute at least \$2.00 during the year in talent money.

The executive officers for 1956 are: President, Mrs. Elsie Tundall; secretary, Mrs. Marg. McConechy; treasurer, Mrs. Edith Lewis.

Special items on the program for the September and October meetings consisted of the reports on the Biennial meeting of the CNA in Winnipeg, by the chapter delegates, Miss Eveline Nicol and Mrs. E. Sanders.

Business discussed at these meetings covered ways and means of raising money. At the October meeting, Miss Vera Spencer, Mrs. Beth Meleike, and Mrs. E. Sanders volunteered to act on a committee to revise the bylaws to conform to the provincial bylaws with regard to committee formation.

A committee consisting of Miss E. Nicol, Mrs. H. G. Pond and Mrs. Jean Harry was formed to arrange for a bake sale.

**SASKATOON**

*City Hospital*

Mrs. Dorothy Parkinson, president, welcomed throngs of guests to the alumnae Chapel Fund tea and bazaar held in mid-September. Mesdames J. D. McNelles and J. Tait were co-conveners of this popular social function that was a great success financially netting a considerable addition to the fund that will be used to assist in building a chapel at the hospital for the use of both patients and staff. While tea was being served models from the Hudson's Bay Company strolled through the crowd displaying smart afternoon and street apparel. The "Parcel Post" table was piled with packages received from graduates all across Canada.

*St. Paul's Hospital*

Approximately 150 student nurses attended a special meeting in September when Miss Margaret Kerr, editor of *The Canadian Nurse* was guest speaker. Miss Kerr emphasized the part a professional journal can and should play in a student's progress toward her goal of becoming a truly professional nurse. The students were urged to write articles, descriptive of the care of patients, for publication.

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**Supervisor, starting salary:** \$255. Must be registered in British Columbia. **Operating Room Nurses, salary:** \$230 plus \$10 'on call.' \$10 postgraduate. **Charge Nurses, salary:** \$245. **General Duty Nurses, salary** \$230. Additional salary paid to nurses with 2 yrs. past experience, plus 4 annual increments to \$40. 28 days vacation, 10 statutory holidays. 1½ days sick leave, cumulative. Room rent at nurses' residence \$20 per mo. Apply Director of Nursing, Trail-Tadanac Hospital, Trail, B.C.

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**Hospital Superintendent & Director of Nurses (Combined)** for 35-bed hospital fully accredited. Good salary. Excellent living quarters. Apply stating references & experience to Chairman, Board of Directors, Fishermen's Memorial Hospital, Box 600, Lunenburg, N.S.

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**Superintendent of Nurses** for 22-bed hospital. Good salary offered. Increments every 6 mo. for 3 yrs. Living accommodation in separate modern nurses' residence. Home equipped with automatic heating & hot water. 1 mo. vacation after 1 yr. employment. Statutory holidays extra. Cumulative sick leave to 90 days. No business matters to handle such as book-keeping, purchasing, admissions, collection of accounts. Apply in writing or phone Sec.-Manager, Union Hospital, Hafford, Sask.

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**Director of Nurses** for 250-bed hospital with school of nursing. Suite in nurses' residence, full maintenance. Good personnel policies. Apply, stating salary expected, age, qualifications, training & experience to Administrator, Union Hospital, Moose Jaw, Sask.

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**Director of Nursing** for 185-bed JCAH accredited General Hospital. Protestant Church affiliated. NLN temporary accredited school of nursing, 75 students. Addition to hospital under construction. Must have B.S. degree in nursing & preferably an M.A. in nursing. Good salary, furnished apt., position open early winter. Apply Administrator, Evangelical Deaconess Hospital, 3245 E. Jefferson Ave., Detroit 7, Michigan.

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**Assistant Director of Nursing** for 800-bed General Hospital with 200-student school of nursing. University education required. Salary depends upon qualifications & experience. Apply to Chairman of Board, Royal Alexandra Hospital, Edmonton, Alberta.

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**Assistant Director of Nursing, Head Nurse, General Duty Nurses** for 150-bed Hospital. 44-hr. wk. 31-days vacation plus statutory holidays, 2-wks. sick leave yearly. Write stating qualifications, salary expected, age & references to Director of Nursing, Grace Dart Hospital, 6085 Sherbrooke St. E., Montreal, Que.

---

**Supervisor of Nursing Service** for 50-bed active General Hospital. Salary: \$210 plus maintenance with 6 monthly bonuses of 5%. 44-hr. wk. 10 statutory holidays & after 1 yr. on staff vacation of 21 days & sick time allowance of 14 days. For further information apply Miss M. Jarvis, Matron, Municipal Hospital Dist. #17, Wainwright, Alta.

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**Supervisor of Nursing (R.N. experienced in nursing service administration desirable)** for new modern 50-bed General Hospital in progressive town (10,000) in Cariboo Dist. central B.C. 14 R.N.'s., 10 Aides, 6 Med. staff. Priv. suite in new residence. Salary commensurate with qualifications. 40-hr. wk., 28 days vacation plus 10 statutory holidays. Sick leave. Travel allowance. Please state age, salary expected, experience & references to Administrator, G. R. Baker Memorial Hospital, Quesnel, B.C.

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**Obstetrical Supervisor, General Duty Nurses (Immediately)** for 40-bed General Hospital. Good salary & personnel policies. Living accommodations available. Apply Supt., Queens General Hospital, Liverpool, Nova Scotia.

**Supervisors & Staff Nurses.** Good salary & personnel policies. Living accommodations available. Apply Director of Nurses, General Hospital, Parry Sound, Ontario.

**Night Supervisor, Assistant Head Nurses & Staff Nurses.** Excellent personnel policies. Apply Director, Shriner's Hospital for Crippled Children, 1529 Cedar Ave., Montreal, Que.

**Operating Room Supervisor** for 118-bed General Hospital, located in a beautiful residential suburb along the North Shore of Chicago. Modern ranch style nurses' homes with attractively furnished private bedrooms. 40-hr. wk. Apply Director of Nursing Services, Highland Park Hospital Foundation, Highland Park, Illinois.

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**Assistant Head Nurses & General Duty Nurses** for 150-bed Communicable Disease Hospital. Apply Director of Nursing, Alexandra Hospital, Montreal, Que.

**Registered Nurses or Non-Registered Nurses if recent graduates (4)** for very active 50-bed hospital. Salary: \$180-\$185 depending on experience, plus complete maintenance & laundering of uniforms. \$5.00 increase every 6 mo. to a maximum of \$200 & 5% bonus every 6 mo. 88-hr. fortnight with rotating 8-hr. shifts. 10 statutory holidays & after 1 yr. on staff vacation of 21 days & sick time allowance of 14 days. For further information apply Miss M. Jarvis, Matron, Municipal Hospital District #17, Wainwright, Alta.

**Registered Nurse** for 36-bed hospital. Starting salary: \$205 per mo. Blue Cross benefits, sick leave etc. Apply Superintendent of Nurses, Hospital District No. 24, Box 330, Altona, Manitoba.

**Registered Nurses.** Single room residence. \$225 per mo. gross. 5 day wk. 20 mi. east of Toronto. Apply Supt. Ajax & Pickering General Hospital, Ajax, Ont.

**Registered Nurses.** Gross salary for nurses currently registered in Ont. \$235 per mo. Good personnel policies. New facilities. Comfortable nurses' residence. 8-hr. rotating shift. 44-hr. wk. 1 day off 1 wk., 2 the next. 1½ days holiday allowed per mo. same sick time accumulated to 90 days. 8 legal holidays per yr. The equivalent of single train fare paid up to \$40 after 1 yr. service. Apply Supt., Lady Minto Hospital, Cochrane, Ont.

**McKellar General Hospital, Fort William, Ont.,** requires **Registered General Duty Nurses.** Good personnel policies. Residence accommodation available at reasonable rates. Hospital has recently completed a well equipped & staffed wing with extensive renovation program progressing in the old section. Apply Director of Nursing.

**Registered Nurses for General Duty.** Initial salary: \$200 per mo.; with 6 or more months Psychiatric experience, \$210 per mo. Salary increase at end of 1 yr. 44-hr. wk.; 8 statutory holidays, annual vacation with pay. Living accommodation if desired. For further information apply Supt. of Nurses, Homewood Sanitarium, Guelph, Ont.

**Registered General Duty Nurses** for active 300-bed hospital. Starting salary: \$210 per mo., 2 annual increases. 30 days vacation per yr. 8 statutory holidays. 44-hr. wk. Transportation refunded up to \$50 after 1 yr. service. Accommodation available in new nurses' residence, if desired. Apply Director of Nursing Service, The General Hospital, Port Arthur, Ont.

**Registered General Duty Nurses** for 200-bed General Hospital. Salary: \$200 per mo. 5½ day wk. Good personnel policies. Apply Director of Nursing, General Hospital, Sault Ste. Marie, Ontario.

**Registered General Duty Nurses** for County Hospital in Huntingdon, 45 mi. from center of Montreal. Excellent bus service. Pleasant working conditions. Nurses' home attached to hospital. Attractive community social life. 8 theatres, bowling, curling & dancing. 8 mi. from summer resort on Lake St. Francis & 12 mi. from U.S. border. Gross salary: \$200 per mo. Three \$5.00 increases at 6-mo. intervals to maximum \$215. 44-hr. wk., 8-hr. duty, rotating shifts. Full maintenance available at \$35 per mo. 2-wk. sick leave. Blue Cross paid. 1 mo. annual vacation, all statutory holidays. Apply Mrs. M. G. Curran, R.N., County Hospital, Huntingdon, Que.

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Apply today! Upon entry you will be offered a permanent or short service commission with officer pay, allowance for uniforms, full maintenance and other benefits including 30 days annual leave with pay and full medical and dental care.

As a Naval Nurse, you'll find real opportunity to advance in your profession! For full information apply to:

MATRON-IN-CHIEF,  
NAVAL HEADQUARTERS, OTTAWA

OR

YOUR NEAREST NAVAL RECRUITING OFFICE



CN-12-56

# Royal Canadian Navy



**Registered Nurses** for modern 52-bed hospital in English speaking community, 50 mi from Ottawa. Salary: \$175 per mo. \$5.00 extra for night duty (3 wks.). 44-hr. wk. 8 hr. duty full maintenance. Sick leave & annual leave. Fare advanced if required. Apply Supt., Pontiac Community Hospital, Shawville, Que.

**Registered Nurses** for 8-bed hospital. Straight 8-hr. shift. Gross salary: \$240-\$260 depending on experience. For further information apply Sr. Superior, Notre Dame Hospital, Val Marie, Saskatchewan.

**Science Instructor** for 200-bed General Hospital. School of Nursing, September classes only. 40-hr. wk., 1 mo. annual vacation, 10 statutory holidays. 1½ days sick leave per mo. cumulative. Apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

**Registered Nurses for charge duty.** Starting salary: \$250 per mo., increase of \$5.00 every 6 mo. to max. of \$275. Evening & night duty \$10 per mo. extra. 40-hr. wk. 2 wk. paid vacation after 1 yr. 6 paid holidays. Meals while on duty. Nurses' home completely furnished, including linen & laundry available for \$30 per mo. Apply County Memorial Hospital, Gooding, Idaho.

**Registered General Duty Nurses for 118-bed General Hospital** along the shores of Lake Michigan, 25 mi. from Chicago. Base salary: \$300. Additional differential of \$30 for evenings & \$20 for nights. 5 day wk. Good personnel policies. Apply Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

**Registered Nurses** for Medical-Surgical, Psychiatric, Obstetrical & Pediatric Units, 325-bed, air-conditioned hospital. Starting salary: \$265 with bonus for evening & night duty. 40-hr. wk. Liberal personnel policies, low cost cafeteria, free laundry. Apply Director of Nursing, Menorah Medical Center, 4949 Rockhill Rd., Kansas City, Missouri.

**Registered Nurses** for staff nursing in new & beautifully equipped 100-bed hospital in the Pacific northwest. Only 6 mi. from the Pacific Ocean. Delightful climate. Beginning salary: \$290 for 40-hr. wk., \$10 additional for p.m. & night duty. Apply Director of Nurses, County General Hospital, Tillamook, Oregon.

**Registered Nurses for General Duty Staff.** Salary commences at £40-10-0 per mo. with full maintenance. Transportation allowance. For full particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

**Registered Nurses.** Excellent opportunities in **Private Nursing** are available in Bermuda. Rates similar to those in effect in Province of Quebec. For information regarding openings write to Matron, King Edward VII Memorial Hospital, Bermuda.

**General Duty Nurses** for 16-bed hospital 25 mi. from Edmonton catering to medical & minor surgical cases. Starting salary: \$230 per mo with perquisites of \$22.50. Usual increments. 1 mo. vacation after 1 yr. service. Please state training, experience, date available & any other pertinent data in application. Apply c/o B. D. Stover, Sec.-Manager, Civic Hospital, Devon, Alberta.

**General Duty Nurse** for 17-bed hospital. Starting salary: \$200 gross. 1 mo. vacation with pay after 1 yr. service. \$5.00 per mo. increase after each 6 mo. service up to 3 increases. Transportation refunded after 6 mo. service. Apply Municipal Hospital, Elnora, Alberta.

**General Duty Nurses, \$230-\$250, Operating Room Nurse, \$250-\$270** including increments. 40-hr. wk. 28 days vacation & 1½ days sick leave monthly. Room & full board \$25 per mo. Fare from Vancouver refunded after 6 mo. service. Apply Matron St. George's Hospital, Alert Bay, B.C.

**General Duty Nurses.** Salary: \$230-270, \$10 increment for experience. 40-hr. wk. 1½ days sick leave per mo. cumulative; 10 statutory holidays, 1 mo. vacation. Must be eligible for B.C. registration. Apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

**General Duty Nurses** for 430-bed hospital; 40 hr. wk. Statutory holidays. Salary \$240-\$273. Credit for past experience. Annual increments; cumulative sick leave; 28 days annual vacation; B.C. registration required. Apply Director of Nursing Royal Columbian Hospital, New Westminster, B.C.

**General Duty Nurses** for 100-bed hospital in north coast city. Salary: \$273 per mo. with 3 yearly increments of \$10. Excellent living accommodation \$40. Good personnel policies. Apply Supt. of Nurses, Prince Rupert General Hospital, Prince Rupert, B.C.

**Royal Jubilee Hospital, Victoria, B.C.** invites applications for **General Duty Nurses** for permanent positions & vacation relief in 500-bed General Hospital. Salary \$227.50-\$262.50 5-day, 40-hr. wk. 4-wk vacation. 10 statutory holidays. Pension plan. Attractive employee benefits. Apply, Director of Nursing.

**General Duty Nurse:** The Blanchard-Fraser Memorial Hospital (71-bed) located in Kentville, Nova Scotia, offers a General Duty Nurse ideal working conditions. 1 mo. annual vacation, excellent personnel policies plus modern living quarters with full maintenance in new nurses' residence. For further information apply to Superintendent of Nurses.

**General Duty Nurses** for 65-bed hospital. Gross salary: \$185-\$210. 44-hr. wk. Statutory holidays. For further information apply Director of Nursing Services, General & Marine Hospital, Collingwood, Ont.



# An Opportunity for 50 NURSES in Hamilton, Ontario!



*The three city-owned hospitals, the General, the Mountain and the Nora-Frances Henderson, have recently undergone an expansion program and are in immediate need of a minimum of 50 Registered Nurses.*



Recognized as one of the most modern-equipped hospitals in Canada, the Hamilton General offers the Registered Nurse working and recreational facilities second to none.



Situated in the heart of what has been termed the "Golden Horse-shoe", Hamilton is a city practically equidistant to Toronto and Buffalo, big enough to be interesting, yet small enough to be friendly and hospitable to the individual.



The rates of pay to Registered Nurses are the highest in the Province of Ontario. For Registered Nurses who work rotating hours of service, the beginning salary is \$53.00 per week. The daily rate is \$10.50 for each eight-hour period of duty.



Hours of duty: (a) 8 hour day—42 hours weekly average—rotating service. DAYS: 7 a.m. to 3.30 p.m. or 10 a.m. to 7 p.m.; EVENINGS: 3 p.m. to 11.30 p.m.; NIGHTS: 11.15 p.m. to 7.15 a.m. These schedules include one half hour for each meal and 15 minutes for morning coffee. (b) Two days off three successive weeks and one day off every fourth week. (c) All statutory holidays or compensatory time.



Vacations: Registered Nurses after one year of service receive 3 weeks vacation with pay. It is less than 200 miles to the beautiful Muskoka Lakes District, less than 2 hours to the U.S. border.

Return coupon to  
**HAMILTON  
GENERAL  
HOSPITAL**

Barton Street East  
Hamilton, Ontario

Please send me more information concerning the opening for 50 nurses at your hospital. My address is:

NAME.....

ADDRESS.....



**General Duty Nurses** for Medical, Surgical, Pediatrics, Obstetrics. Good salary & personnel policies. Apply Director of Nursing, Victoria Hospital, London, Ont.

**General Duty Nurses** for all departments. Gross salary: \$210 per mo. if registered in Ontario \$200 per mo. until registration has been established. \$20 per mo. bonus for evening or night duty; annual increment of \$10 per mo. for 3 yrs. 44-hr. wk., 8 statutory holidays, 21 days vacation & 14 days leave for illness with pay after 1 yr. of employment. Apply: Director of Nursing, General Hospital, Oshawa, Ont.

**General Duty Nurses (2)** for new 173-bed hospital. Good personnel policies. Starting salary: \$215 per mo. 44-hr. wk. Apply Director of Nurses, Plummer Memorial Public Hospital, Sault Ste. Marie, Ontario.

**General Duty Nurses** for 60-bed General Hospital. Good salary & personnel policies 44-hr wk. All statutory holidays. Sick leave allowance. Apply Supt., Public Hospital, Smiths Falls, Ontario.

**General Duty Nurses (2)** for 20-bed modern hospital. Salary: \$200 per mo. plus full maintenance. Usual holidays with pay, sick leave etc. Fare refunded one way after 1 yr. Separate modern nurses' home. Apply Matron, Union Hospital, Vanguard, Sask.

**General Duty Nurses** for 650-bed teaching hospital in central California. Salary: \$303-\$356 per mo. 40-hr. wk. Liberal vacation, holiday & sick leave plan. Apply Personnel Office, 510 E. Market St., Stockton, California.

**General Staff Nurses** for 400-bed Medical & Surgical Sanatorium, fully approved student affiliation & postgraduate program. Full maintenance. Recreational facilities. Vacation with pay. Sick benefits after 1 yr. Blue Cross coverage. Attractive salary; 40-hr. wk. For further particulars apply Supt. of Nurses, Nova Scotia Sanatorium, Kentville, N.S.

**Staff Nurses** for 600-bed General & Tuberculosis Hospitals with student programs. In central valley, city of 108,000. State & Junior Colleges afford opportunity for advanced education. Salary \$300 with 4 annual increases to \$341. Full maintenance \$45 per mo. Liberal personnel policies. Apply Assoc. Director of Nursing Service, County General Hospital, Fresno, California.

**General Staff Nurses (Men & Women)**, for well equipped 400-bed General Hospital. An opportunity to learn nursing team leadership. Monthly salaries: \$310-\$350 plus differential of \$30 monthly for evenings or nights. Attractive individual rooms available, \$20-\$25 per mo. Convenient transportation to colleges & close by famous loop. Write to Dept. CNJ, Mount Sinai Hospital Medical Center, 2750 West, 15th Place, Chicago 8, Illinois.

**Staff Nurses** for 500-bed General Hospital. Beginning salary: \$300 per mo. with advancement to \$335 for those eligible for registration in the state of Michigan. Additional differential \$1.50 per afternoon or night. 40-hr. wk. Hospital & school of nursing fully approved. Apply Director of Nursing, The Grace Hospital, 4160 John R. St., Detroit 1, Michigan.

**General Duty Staff Nurses** for 185-bed General Hospital. School of nursing. Basic salary: days, \$265, evening & night shifts, \$275. 40-hr. wk. Annual vacation, 6 paid holidays. Sick leave, 12-days per yr. Write to Director of Nursing Service, St. Vincent Hospital, Billings, Montana.

**Staff Nurses** for 225-bed General Hospital, on outskirts of New York City. Salary: \$240-\$280. \$30 for permanent evening duty, \$25 for permanent night duty. Apply Director of Nursing, St. John's Riverside Hospital, Yonkers N.Y.

**Graduate Nurses (4)** for permanent staff Municipal Hospital. Net salary \$180 per mo. with full maintenance. At the end of each 6-mo. period on staff Graduate nurses will receive a bonus of \$120 thus making the net salary in effect \$200 per mo. before income tax. 2 day vacation time is earned each full mo. worked, 8 statutory holidays in addition. Liberal sick pay & free hospitalization included in plan. We have a very nice residence for the nursing staff & are only 2 hrs. from Calgary by Trans-Canada highway or C.P.R. main line. You will like it here. Apply Matron, Municipal Hospital, Bassano, Alta.

**Assistant Graduate Nurse (Immediately)** for the Wainwright Clinic. Please state qualifications & salary expected. Apply to Drawer 699, Wainwright, Alberta.

**Graduate Nurses (3)** for 24-bed hospital. Salary: \$230 per mo. if B.C. registered; less \$40 board, lodging, laundry. 1 mo. vacation after 1 yr. on full pay. 1½ days sick leave per mo. cumulative. Apply, stating experience to Matron, Terrace & District Hospital, Terrace, British Columbia.

**Graduate Nurses** for full time positions in 91-bed General Hospital in central B.C. Expanding community with new hospital planned. Salary: \$235 per mo. depending on experience. 28-days annual vacation. Liberal sick leave allowance & other perquisites. Room & board available for nominal charge. Transportation refunded after 6 mos. Apply Director of Nursing, Prince George & District Hospital, Prince George, B.C.

**Graduate Nurses (General Staff Positions)** for General Hospital. Salary: \$239. per mo. as minimum & \$277.25 as maximum, plus shift differential for evening & night duty. 40-hr. wk. Temporary residence accommodation is available. Applicants not registered in B.C. should forward a letter of acceptance of registration in B.C. from the Registrar of Nurses, 2524 Cypress St., Vancouver, B.C. Please apply Personnel Dept., Vancouver General Hospital, Vancouver, B.C.



# NURSING WITH INDIAN AND NORTHERN HEALTH SERVICES



## OPPORTUNITIES FOR REGISTERED HOSPITAL NURSES, PUBLIC HEALTH NURSES, and NURSING ASSISTANTS or PRACTICAL NURSES

for Hospital Positions and Public Health Positions in Outpost Nursing Stations, Health Centres and Field Positions in the Provinces, Eastern Arctic and North-West Territories.

### SALARIES



- (1) Public Health Nursing Supervisors: up to \$4,620 depending on qualifications and location.
- (2) Directors of Nursing in Hospitals: up to \$4,620 depending on qualifications and location.
- (3) Public Health Staff Nurses: up to \$3,600 per year depending on qualifications and location.
- (4) Hospital Staff Nurses: up to \$3,420 per year depending upon qualifications and location.
- (5) Nursing Assistants or Practical Nurses: up to \$185 per month depending upon qualifications and location.

- Room and board in hospitals — \$30 per month. Statutory holidays. Three weeks' annual leave with pay. Generous sick leave credits. Hospital-medical and superannuation plans available.

- Special compensatory leave for those posted to isolated areas.

For interesting, challenging, satisfying work, apply to — Indian and Northern Health Services at one of the following addresses:

- (1) Regional Superintendent, 4824 Fraser Street, Vancouver 10, B.C.
- (2) Regional Superintendent, c/o Charles Camell Indian Hospital, Edmonton, Alberta.
- (3) Regional Superintendent, 735 New Federal Building, Regina, Saskatchewan.
- (4) Regional Superintendent, 522 Dominion Public Building, Winnipeg 1, Manitoba.
- (5) Zone Supervisor of Nursing, Box 292, North Bay, Ontario.
- (6) Zone Supervisor of Nursing, P.O. Box 3427, St. Roch Branch, Quebec, Que.
- (7) Moose Factory Indian Hospital, Moose Factory, Ontario.

or

Chief, Personnel Division, Department of National Health and Welfare, Ottawa, Ontario.

**Graduate Nurses** for new, very modern 88-bed hospital in a pleasant progressive town. Nurses salary: \$200 per mo. Annual increase \$10 per mo. for 3 yrs. 2-wk. shift rotation, bonus for night shifts. 1 hr. drive to Toronto & several resorts. Local swimming pool, bowling alleys, skating, theatres etc. Apply Director of Nurses, Dufferin Area Hospital, Orangeville, Ont.

**Graduate Nurses** for duty on Obstetrical, Medical & Surgical Wards. Personnel policies as recommended by the Assoc. of Nurses of the Prov. of Quebec. Please apply Director of Nursing, Queen Elizabeth Hospital of Montreal, 2100 Marlowe Ave., Montreal 28, Que.

**Graduate Nurses** for general staff duty in a tuberculosis hospital for treatment of adult medical patients. For further information, apply to Director of Nursing, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, P.Q.

**Supervisor (qualified.)** Good salary. Extra allowance for experience if French speaking 5-day wk., 4-wk. vacation, 18 days sick leave cumulative annually. Car is provided. Half cost of uniform is allowed & half of Blue Cross. Workmen's Compensation. Good working conditions. Apply Sec.-Treas., Porcupine Health Unit, 164 Algonquin Blvd. E. Timmins, Ont.

**Public Health Nurse Grade 1.** British Columbia Civil Service, Dept. of Health & Welfare. Starting Salary \$255, \$260, \$266 per mo., depending on experience, rising to \$298. per mo. Promotional opportunities available. Qualifications: Candidate must be eligible for registration in British Columbia & have completed a University degree or Certificate course in Public Health Nursing. (Successful candidates may be required to serve in any part of the Province.) Cars are provided. 5-day wk. in most districts. Uniform allowance. Candidates must be British subjects; preference is given to ex-service women. Application forms obtainable from all Government Agencies, the Civil Service Commission, 544 Michigan St., Victoria, or 411 Dunsmuir St., Vancouver 3, to be completed & returned to the Chairman, Civil Service Commission, Victoria. Further information may be obtained from the Director, Public Health Nursing, Dept. of Health & Welfare, Parliament Bldgs., Victoria, B.C.

**Public Health Nurses** for generalized program in Seaway Development Area. Minimum salary: \$2,800 with allowance for experience. Group insurance & Blue Cross available. Good transportation policy. Apply R. S. Peat, M.D., Medical Officer of Health, S. D. & G. Health Unit, 104 Second St. W., Cornwall, Ont.

**Public Health Nurse (1)** for generalized program in rural & semi-urban area adjacent to metropolitan Toronto. Excellent working conditions including pension plan, group ins. & transportation arrangements. Apply Dr. R. M. King, York County Health Unit, Newmarket, Ont.

**Public Health Nurses (2)** for generalized program in city of 43,000. Blue Cross & P.S.I. employer shared. Transferrable accumulative sick leave & pension plans. Workmen's Compensation. Group insurance available. Transportation provided or allowance -- 10¢ first 2,000 mi. 8¢ per mi. thereafter. 5-day wk. 1 mo. vacation with extra time at Christmas. Salary scale: \$3,000 for inexperienced nurses to start with annual increments of \$150. All starting salaries dependent on experience. For further information please write supplying details of training & experience to Medical Officer of Health, City Hall, Peterborough, Ontario.

**Public Health Nurses (qualified.)** Salary: \$3,100 depending on dist. served, less if in the Timmins area. Annual increment \$150 per annum for 4 yrs. Additional allowance for experience & if French-speaking. 5-day wk. 4-wk. vacation, 18 days sick leave annually (cumulative) Car is provided. Half cost of uniform is allowed & half of Blue Cross Workmen's Compensation. Good working conditions. Apply Sec.-Treas., Porcupine Health Unit, 164 Algonquin Blvd. E., Timmins, Ont.

**Public Health Nurses (Qualified)** for a generalized program in Etobicoke Township (suburb of Toronto). Minimum salary: \$3,200 Annual increments to \$3,680. Starting salary based on experience. Car allowance \$670 per annum. 4 wk. vacation after 1 yr. Blue Cross & Pension Plan. Apply Director of Public Health Nursing Township of Etobicoke 4946 Dundas St. W., Toronto 18, Ont.

**Matron** for 23-bed hospital (Immediately). Salary: \$270-\$295. We have 2 doctors & full complement of nurses. Good farming area. Green Water Lake summer resort nearby. Please state experience & apply P. Tomyln, Sec-Manager, Union Hospital, Kelvington, Sask.

**Registered General Duty Nurses** for 18-bed active hospital. Good salary. 44-hr. wk. 3-wk. vacation, statutory holidays & sick leave benefits. Apply administrator, District Hospital, Shelburne, Ont.

**Graduate General Duty Nurses** for 52-bed hospital situated on main line between Edmonton & Calgary. Salary: \$236 gross less \$26 maintenance. 3 increments after 6 mo. 1 yr. & 2 yr. service. 1 mo. vacation after 1 yr. service. Please apply to Mrs. J. Harvie Matron, Municipal Hospital, Lacombe, Alta.

**Dietitian** for completely new 250-bed hospital. 70-student school of nursing. For further information please apply to Administrator, Hotel Dieu Hospital, Cornwall, Ontario.

**REGINA  
GENERAL HOSPITAL**

**SCHOOL OF NURSING  
Regina, Saskatchewan**

*Requires the following personnel  
immediately:*

Assistant Educational Director

Assistant Nursing Arts Instructor

Medical Clinical Instructor

Excellent salary & personnel policies.

1 class a year admitted to school.

New modern teaching unit.

800-bed hospital.

APPLY TO: DIRECTOR OF NURSING

**NURSES — REGISTERED  
CALIFORNIA**

For General Duty for beautiful new 112-bed modern hospital just opened. Advancement to Supervisory positions for early applicants. Salary: \$310 to begin, \$320 for evening & night shifts. Merit increases, 40-hr. wk., annual vacation & holidays with pay. Sick leave, hospitalization insurance provided. Dynamic, lovely California city in beautiful San Joaquin Valley, 2 hr. from Los Angeles. Transportation costs to California will be reimbursed to applicants after 1 yr. Nurses needed immediately, early applicants & first arrivals will receive premium attention. Housing available.

Send full particulars immediately to:

DIRECTOR OF NURSES,  
GREATER BAKERSFIELD MEMORIAL HOSPITAL,  
420-34th ST., BAKERSFIELD, CALIFORNIA

**Calling All  
Canadian  
Graduate Nurses**

- **How would you like to work and live in the heart of Manhattan?**

THE ROOSEVELT HOSPITAL, a voluntary, general hospital, offers you this opportunity.

- **Why not enjoy these benefits offered by Roosevelt?**

BASE SALARY — Begins at \$270 per month, without experience. Experience qualifies for higher starting salary.

INCREMENTS — Start after first 6 months and continue annually.

BONUSES — \$40 for evening and \$20 for night duty.

VACATION — 4 weeks annually.

HOLIDAYS — 10 annually.

LAUNDRY SERVICE

HOSPITALIZATION

HEALTH SERVICE

SOCIAL SECURITY

*For further information write to:*  
**DIRECTOR OF NURSING,  
DEPARTMENT NS,  
ROOSEVELT HOSPITAL  
59th Street West,  
New York City**



**Matron (R.N.)** for modern 12-bed hospital. Plans for additional 12-beds & new nurses' home in spring. Starting salary: \$250 per mo. with full maintenance. Annual increment \$10 per mo. to \$280. **Registered Nurse (1)**, starting salary: \$180 with full maintenance. Annual increment of \$10 per mo. to \$210. 3-wk. vacation with pay after 1 yr. service, 4-wk. thereafter. Apply Mrs. N. E. Parkinson, R.N., Matron, District Hospital, Shoal Lake, Man.

**Supervisor**, starting salary: \$245 (must be registered in Sask.). **Charge Nurses**, starting salary: \$235. **General Duty Nurses**, salary: \$220. 6 increments of \$5.00 per mo. every 6 mo. 28-day vacation plus 9 statutory holidays. Full maintenance, \$30 per mo. if desired. Apply Director of Nursing, Victoria Hospital, Prince Albert, Sask.

**Nursing Instructor** responsible for affiliation program in Tuberculosis nursing. Applicants should state qualifications, experience, age, marital status & salary expected. Attractive suite available in modern nurses' residence. For further information apply Director of Nursing, Essex County Sanatorium, Windsor, Ontario.

**Registered Nurses (2)** for active 16-bed hospital. Salary: \$200 plus full maintenance. 4, \$5.00 increases at 6-mo. intervals. 3-wk. annual vacation, all statutory holidays. 1½ days sick leave allowed per mo. cumulative to 30 days. Send applications or requests for further information to Miss A. N. Routledge, Matron, Municipal Hospital, Glendon, Alta.

**Registered General Duty Nurses (2)** for modern 35-bed hospital 80 mi. east of Edmonton. Salary: \$217.50 less \$25 maintenance. 4 semi-annual increases of \$5.00. 44-hr. wk. 1 mo. vacation with pay after 1 yr. service. Sick leave benefits. Apply Mrs. S. Brower, Matron, Municipal Hospital, Viking, Alta.

**Registered Nurses or Graduate Nurses (2)** for fully modern 30-bed hospital. Gross starting salary: \$210 & \$200 per mo. respectively less \$25 for full maintenance. Salary increased according to experience. Overtime. \$5.00 increment after each 6-mo. service. 44-hr. wk. 4-wk. vacation with pay after 1 yr. service. All statutory holidays. Accumulative sick leave. Separate living quarters. Apply Supt., District Hospital, Roblin, Manitoba.

**Registered Nurses (2)** for 60-bed hospital. Salary: \$180 plus full maintenance. Increment after 1 yr. service for 4 yrs. 8-hr. duty. 28 days vacation. Residence accommodation. Apply Supt. of Nurses, Alexandra General & Marine Hospital, Goderich, Ont.

**Public Health Nurses (Qualified)** for generalized public health nursing service. Salary range: \$3,284-\$3,729. Starting salary based on experience. Annual increments. 5-day wk. Vacation. Shared hospitalization, sick pay & pension plan benefits. Apply Personnel Dept., Room 320, City Hall, Toronto, Ont.

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An Exceptional  
Opportunity at

## NEW ROCHELLE HOSPITAL

New Rochelle, New York

A Voluntary, general hospital of 306 beds. Located in Westchester County, adjoining New York City.

**BASE SALARY**—Begins at \$275. in cash per month, plus 2 meals and laundry.

**INCREMENTS**—\$5.00 every six months for a period of four years.

**PREMIUM**—\$25. for evening and for night duty.

**VACATION**—2 weeks first year; 3 weeks second year; 4 weeks thereafter.

**HOLIDAYS**—8 annually.

**HOSPITALIZATION**

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**LOCATION**—20 miles from New York City—on Long Island Sound. Train service every half hour to and from the City.

For further information write to:

**DIRECTOR OF NURSING  
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Personnel policies as recommended by A.N.P.Q.

Apply: DIRECTOR OF NURSING, 2100 Marlowe Ave., Montreal 28, Que.

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Requires

General Staff Nurses for Medical, Surgical, Obstetrical and Pediatric Services. Forty hour week. Salary \$220 to \$260 gross per month. Differential for evening and night duty, Residence Accommodation if desired.

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DIRECTOR OF NURSING, UNIVERSITY HOSPITAL,  
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*has Staff and Supervisory positions in various parts of Canada.*

*Personnel Practices Provide:*

- Opportunity for promotion.
  - Transportation while on duty.
  - Vacation with pay.
  - Retirement annuity benefits.

*For further information write to:*

**Director in Chief,**  
Victorian Order of Nurses for Canada,  
193 Sparks Street, Ottawa 4, Ont.

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for

New 87-bed hospital for  
Chronically Ill

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New 165-bed Home for the Aged

Salary according to specifications &  
experience.

Apply: Mr. S. Ruth, Administrator, Jewish  
Home for the Aged,  
3560 Bathurst St., Toronto 12, Ontario

## GRADUATE NURSES

*required for*

**GENERAL STAFF DUTY**

in Medical and Surgical services of

**TORONTO  
GENERAL HOSPITAL  
101 COLLEGE ST.,  
TORONTO**

# **WESTERN MEMORIAL HOSPITAL**

**Corner Brook, Newfoundland**

*requires immediately*

## **OPERATING ROOM NURSES**

For modern well equipped Operating Room. Good conditions of service.  
Return fare paid by hospitals after completion of 1 yr's. service.

*Apply: SUPERINTENDENT OF NURSES*

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**HEAD NURSE, NURSERY**

*(Postgraduate experience preferred)*

**New 300-bed General Hospital.      Excellent personnel policies.**

*For further information apply:*

**DIRECTOR OF NURSING, MEMORIAL HOSPITAL,  
REGENT ST. S., SUDBURY, ONTARIO.**

# **VICTORIA PUBLIC HOSPITAL**

**Fredericton, N.B.**

**APPLICATIONS ARE INVITED FOR THE POST OF  
SUPERINTENDENT OF NURSES**

This 170-bed hospital is situated in the University city of Fredericton. Immediate expansion planned for a further 100-beds. Full details of position & salary will be available to applicants, who should state qualifications.

**APPLY TO: R. H. STOCKER, ADMINISTRATOR**

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**\$2,610-\$3,360**

# **CERTIFIED NURSING ASSISTANTS**

**\$2,040-\$2,220**

**SUNNYBROOK HOSPITAL  
TORONTO**

**5-day week**

**WESTMINSTER HOSPITAL  
LONDON**

Application forms, available at your nearest Civil Service Commission Office,  
National Employment Service & Post Offices, should be forwarded to the

**CIVIL SERVICE COMMISSION,  
25 ST. CLAIR AVE. E., TORONTO 7, ONTARIO**



# Official Directory

## Provincial Associations of Registered Nurses

### ALBERTA

#### Alberta Association of Registered Nurses

Pres., Miss E. Bietsch, Gen. Hosp., Medicine Hat; Vice-Pres., Miss E. Shaw, Srs. C. Leclerc, M. Gerala. *Committees: Nursing Service*, Miss M. Street; *Nursing Education*, Miss G. Hall; *Public Relations*, Miss W. Norquay; *Legislation & By-Laws*, Miss I. Johnson; *Finance*, Miss M. MacDonald; *Student Nurses' Association Adviser*, Miss E. Farquharson. *Sec.-Registrar*, Mrs. Clara Van Dusen, Ste. 5, 10129-102nd St., Edmonton.

#### Ponoka District 2

Pres., Mrs. E. Coombs; Vice-Pres., Mr. Almond; Sec.-Treas., Miss E.M. Baker, Box 118. *Committee: Program*, Misses E. Kemp, M. Petersen, M. Fawcett. *Rep. to: The Canadian Nurse*, Miss E. Funk.

#### Calgary District 3

Pres., Miss A. Fallis; Vice-Pres., Mrs. G. Duthie; Sec., Miss J. Cummins, 1228 Kensington Rd.; Treas., Mrs. N. Mellan, 1806-1st St. E. *Committees: Program*, Misses E. Heaven, L. Bibby; *Refreshments*, Mrs. F. Quaife, Miss M. Hough; *Nursing, Institutional*, Miss M. Brown; *Public Health*, Miss F. Moore; *Private*, Mrs. A. Stewart; *Rep. to The Cdn. Nurse*, Sr. Desmarais, Holy Cross Hospital.

#### Medicine Hat District 4

Pres., Mrs. A. Renner; Past Pres., Mrs. C.R. McKay; Vice-Pres., Mrs. F. Batter; Rec. Sec., Miss J. Buck, 862-B, 3rd St. S.E.; Treas., Mrs. D. Folkins, 957 Queen St. *Committees: Program*, Miss D. Schafer; *Registry*, Mrs. A. Dederer; *Telephone*, Mrs. C.E. Keating.

#### Red Deer District 6

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## QUEBEC

### The Association of Nurses of the Province of Quebec

The Association of Nurses of the Province of Quebec, created by Licensing Act, April 17, 1946, replacing The Registered Nurses Association of the Province of Quebec

Incorporated February 14, 1920.

Pres., Mlle Eve M. Merleau, 3201 ave Forest Hill, Montréal; Vice-Pres., (Eng.), Sr. M. Felicitas, Miss E. Geiger, (Fr.), Mlle F. Verret, L. Couet; Hon. Sec., Sr. J. Forest; Hon. Treas., Miss M. M. Wheeler; Councillors: Mlle L. Lapointe (Dist. 1), R. Aubin (Dist. 3), Marie-Jeanne Clairmont (Dist. 5), A. Mailloux (Dist. 7), G. Lamarre (Dist. 9). The above constitute the Executive Council and are Members of the Committee of Management, together with: Mlle G. Gosselin, M. Gauthier, M. Jalbert, A. Girard, J. Reynolds, J. Ouimet, Misses G. Purcell, A. Christie, Mmes R. M. Duhaime, J. Morency, Srs. St-François-Xavier, Barcelo. *Advisory Committee:* Misses R. Chittick, J. Radley-Walters, C. Aitkenhead, E. C. Flanagan, C. V. Barrett, H. Lamont, Mlle A. Martineau, J. Gagnon,

S. Pilon, Srs. Valérie de la Sagesse, St-Ferdinand, D. Lefebvre. *Committee Chairmen:* Nursing Education, Sr. D. Lefebvre, Miss H. Lamont; Nursing Service, Miss G. Purcell, Mlle G. D. Côté. *Chairmen, Board of Examiners (Eng.):* Miss A. Haggart, Royal Victoria Hosp., Montréal; (Fr.), Mlle J. Trudel, Hôpital Ste-Justine, Montréal. *Sec.-Registrar, Miss A. Winonah Lindsay. Visitor to French Schools of Nursing, Mlle Suzanne Giroux. Association Headquarters, 1538 Sherbrooke St. W., Montréal 25.*

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### Medicine Hat General Hospital

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### St. Joseph's General Hospital, Vegreville

Pres., Sr. M. A. Knievel; Past Pres., Mrs. C. Dougan; Vice-Pres., Miss E. Wicentowich; Rec. Sec., Mrs. D. Chester, Vegreville. *Rep. to The Canadian Nurse, Sr. H. Levasseur.*

## BRITISH COLUMBIA

### Royal Inland Hospital, Kamloops

Pres., Mrs. J. J. Waugh; Past Pres., Mrs. J. Hodgson; Vice-Pres., Mmes M. Walker, M. Hall; Rec. Sec., Mrs. W. R. Waugh, 694 Seymour St.; Treas., Mrs. R. J. Jamieson, 551 Seymour St. *Committees: Gifts, Mrs. S. D. A. Cleish; Ways & Means, Mrs. R. Bell.*

### St. Paul's Hospital, Vancouver

Hon. Pres., Sr. Superior M. Celina; Hon. Vice-Pres., Sr. M. de Loyola; Pres., Mrs. G. Collishaw; Vice-Pres., Mmes M. Banner, O. Lockhart; Rec. Sec., Miss J. Morrissey; Corr. Sec., Mrs. C. Fordyce, No. 31, 1490 Laburnum; Treas., Miss G. Corcoran, 150 E. 50th Ave.; Asst. Treas., Mrs. I. Thomson. *Committees: Finance, Mrs. A. Barnes; Bursary Loan, Miss G. Armson; Sick Benefit, Benevolent & Emergency Loan, Mrs. F. Whitney; Program, Miss H. Hull; Social, Mrs. P. Tapping; Publicity, Miss P. White; Visiting, Mrs. A. Barnes; Sports, Miss A. Owens; Public Relations, Mrs. D. Murray; Alumnae Bulletin Ed., Miss M. Freeze; Rep. to: The Cdn. Nurse, Miss D. Corry.*

### Vancouver General Hospital

Hon. Pres., Miss H. King; Pres., Mrs. T. Hopkins; Past Pres., Mrs. R. Campbell; Vice-Pres., Mmes B. DuGas, K. Pettigrew, J. Biden; *Exec. Member, Mrs. M. Saunders; Exec. Sec., Mrs. M. Faulkner, 587 W. 18th Ave. Committees: Education, Mrs. D. Kirkwood; Membership, Mrs. C. Donaldson; Program, Miss S. West; Publicity, Mrs. A. Jones.*

### Royal Jubilee Hospital, Victoria

Pres., Mrs. E. Bolt; Past Pres., Mrs. M. Conyers; Vice-Pres., Mmes E. Pite, B. Owen; Rec. Sec., Mrs. B. Chater, 288 View Royal Ave.; Asst. Sec., Mrs. C. McLaren; Treas., Mrs. V. McConnell, 2406 Central Ave. *Committees: Membership, Mrs. M. McCague; News Bulletin, Miss C. Fatt; Social, Mrs. J. Litster; Telephone, Mrs. G. Graham; Visiting, Miss M. Strachan.*

### St. Joseph's Hospital, Victoria

Hon. Pres., Sr. M. Angelus; Hon. Vice-Pres., Mrs. M. Lucita, M. Gregory; Pres., Mrs. E. Boak; Vice-Pres., Mmes J. Hogarth, M. Piggott; Rec. Sec., Mrs. R. Oakman; Corr. Sec., Mrs. J. A. Drear, 3905 Cadboro Bay Rd.; Treas., Mrs. J. Welch. *Councillors: Mmes C. Ness, A. Deeks, R. Ditchburn; M. Grant. Committees: Publicity, Mrs. R. Kersey; Membership, Mmes V. Rose, Gehrke, P. Fatt, Miss A. Mottram; Sick Visiting, Mrs. A. McKenzie, Miss D. Vawden; Refreshments, Mrs. M. Kissingner, Misses M. Schleppe, H. Aujla. Resolutions, Mrs. E. Gandy, Miss M. Constable; Pins, Sr. M. Claire; Telephone, Mrs. Roach, Misses Shong, Hadley; Program, Mrs. Bridge; Cards, Mmes McLuhan, Playfair, Aaronson; Vital Statistics, Miss N. Martin; Maintenance, Mmes E. Gandy, I. Moore; Mary Thompson Fund, Mmes E. Boak, J. Welch.*

## MANITOBA

### St. Boniface Hospital

Hon. Pres., Sr. D. Clermont; Pres., Mrs. R. McNaughton; Past Pres., Miss M. Gibson; Vice-Pres., Miss T. Greville, Mrs. A. Lemoine; Rec. Sec., Miss P. Hanna; Corr. Sec., Miss B. Boldt, 46 Hart Ave., Elmwood; Treas., Mrs. M. Shaw, 748 Walker Ave., Fort Rouge; *Archivist, Miss S. Dmyterko. Committees: Advisory, Miss W. Grice; Legislation, Mrs. M. Albi; Membership, Mrs. M. Gerrie; News Bulletin, Mrs. B. Lambert; Scholarship, Miss L. Wiebe; Social, Mrs. H. Adam; Visiting, Miss J. Armstrong. Reps. to: Local Council of Women, Mrs. D. C. McDonald; Press, Mrs. J. Gauthier; Provincial Assoc., Miss V. Williams; The Canadian Nurse, Mrs. J. Gauthier.*

## Children's Hospital, Winnipeg

Pres., Mrs. W. J. McCord; Vice-Pres., Miss D. Motrik; Rec. Sec., Miss C. Kidd; Corr. Sec., Miss M. Hall, 917 Somerset Ave., Winnipeg 9; Treas., Miss P. Greenaway, 577 Johnson Ave. *Committees:* Visiting, Mrs. H. Davis; Refreshments, Mrs. I. Moore; Phoning, Mmes J. Brown, J. C. Kirby; Program, Misses S. O'Grady, S. Pitt; Rep. to Local Council of Women, Miss J. Boyd.

## Grace Hospital, Winnipeg

Hon. Pres., Brig. G. Gage; Pres., Mrs. J. G. Hunter; Past Pres., Mrs. J. Hodgkins; Vice-Pres., Mrs. B. Gregory; Membership Sec., Mrs. G. G. M. Baisley, 967 Polson Bay; Sec., Miss J. Mensforth; Treas., Mrs. L. B. Orton, 352 Conway St. *Committees:* Publicity, Mrs. J. A. Thompson; Entertainment, Mrs. N. Pearce; Ways & Means, Mrs. W. A. Sheidow, Miss J. Tidsbury.

## Misericordia Hospital, Winnipeg

Hon. Pres., Sr. St. Odilon, Miss G. Thompson; Pres., Mrs. R. (Steiner) Smith; Vice-Pres., Mrs. E. (Frith) Mather; Rec. Sec., Miss A. McGill; Corr. Sec., Miss P. Kovacs, 538 Montrose Ave., East Kildonan; Treas., Miss B. Green. *Committees:* Archivist, Miss M. Lang; Visiting, Mrs. N. (Shaw) Galgan; Program, Miss V. Trudel; Advisory, Mmes M. Cruden, S. Hutton, E. McLaren; Membership, Miss V. Dutka, Mrs. Rathwell; Lunch, Misses E. Gracey, J. Billman; Bulletin, Editor, Miss K. Ball, Co-editor, Miss E. Christianson; Mailing, Mmes M. Johnson, D. Pound, P. Burkett; Reporters, Mrs. D. Peate, Miss M. Oddstead. Reps. to: The Cdn. Nurse, Misses M. LaCroix, L. Hitchie; M.A.R.N., Miss A. Bannatyne; Nurses' Directory, Miss A. Gunn; Local Council of Women, Mrs. J. McTavish; Blue Cross, Miss S. Boyne.

## Winnipeg General Hospital

Hon. Pres., Mrs. J. Morrison; Pres., Miss J. Whitford; Past Pres., Mrs. J. E. Wilson; Vice-Pres., Mmes G. Kent, J. M. Ridge, W. J. McKear; Rec. Sec., Miss E. Henderson; Corr. Sec., Mrs. G. Maclean; Treas., Miss A. Foster, 30 Emily St. *Committees:* Program, Miss J. DeBrincat; Membership, Mrs. H. Daniels; Sick Visiting, Miss A. Howard; Journal, Mmes A. Hughes, G. Beatson, Miss R. Pold; Scholarship, Miss M. Hart; Chapter Correspondent, Miss J. Kerr. Reps. to: School of Nursing, Mrs. J. Wilson; Local Council of Women, Mrs. R. Emmett; Welfare Council, Mrs. H. Johnston; The Cdn. Nurse, Mrs. W. Allison.

## NEW BRUNSWICK

### Victoria Public Hospital, Fredericton

Pres., Miss L. Currie; Vice-Pres., Mmes R. Howie, A. Shanks, Miss R. Symonds; Sec., Miss A. Downing, Fredericton Med. Clinic, Fredericton; Asst. Sec., Mrs. L. Anderson; Treas., Mrs. L. Smith, 641 York St., Asst. Treas., Mrs. P. Cassidy. *Additional Exec. Members:* Miss M. Jewett, Mrs. E. Doyle.

### Saint John General Hospital

Hon. Pres., Mrs. J. H. Vaughan; Pres., Mrs. J. Stirling; Past Pres., Miss M. Moore; Vice-Pres., Mmes E. T. K. Mooney, R. Costello; Rec. Sec., Mrs. G. Somerville, 416 Windsor St., Lancaster; Asst. Corr. Sec., Miss K. Donahue; Treas., Mrs. D. Crawford, 83 Parks St.; Asst. Treas., Mrs. W. McKinnon. *Additional Exec. Members:* Misses P. Harrity, B. Nelson. *Committees:* Program, Miss M. Todd; Refreshments, Mrs. M. M. O'Neal. Rep. to: Historical Society, Miss S. Wetmore.

## NEWFOUNDLAND

### Grace Hospital, St. John's

Pres., Miss E. Thomas; Vice-Pres., Capt. M. Snook; Sec., Mrs. J. Miffin, 121 St. Clare Ave.; Treas., Mrs. M. Hudson. *Committees:* Social, Mmes J. Fogwill, N. Strong; Program, Mrs. M. Moores, Miss R. Parsons; Editor of "The Link", Cant. M. Snook; Assoc. Editor, Mrs. A. Howse; Exec., Mmes N. Lester, D. Muford, A. Dicks, B. Oakley, M. Buzzy, D. Vavasour, Miss E. Botterill.

### St. John's General Hospital

Hon. Pres., Mrs. P. Barrett; Pres., G. Farrell; Past Pres., Miss M. Feehan; Vice-Pres., Mrs. D. Wyatt; Sec., Miss G. Rowsell; Asst. Sec., Miss V. Penney; Treas., Miss C. Tobin, General Hospital. Asst. Treas., Miss F. Mills. *Committees:* Entertainment, Mrs. R. Parsons; Education, Miss J. Story; Finance, Miss P. Godden.

## NOVA SCOTIA

### Nova Scotia Hospital, Dartmouth

Pres., Mrs. A. Smith; Vice-Pres., Mr. J. Nunn; Sec., Miss M. Forbes, N.S. Hosp.; Treas., Mrs. D. Coudle, Box 67, Shearwater. *Committees:* Program, Mmes C. Caudle, M. Keddy; Refreshments, Mrs. M. Whelly; Ways & Means, Mrs. J. Bonang; Visiting, Mrs. K. Manley; Publicity, Mrs. J. Richard.

### Glace Bay General Hospital

Pres., Mrs. M. MacDonald; Vice-Pres., Miss A. Butt; Rec. Sec., Mrs. V. Atkinson; Corr. Sec., Mrs. A. MacFee, 4 Bower St.; Treas., Mrs. M. Fraser, 40 Catharine St. *Committees:* Publicity, Mrs. A. MacFee; Program, Miss A. MacDonald, Mrs. R. Adams, Mrs. M. Peach.

### Halifax Children's Hospital

Hon. Pres., Miss M. Dunbar; Pres., Mrs. J. Hussey; Past Pres., Mrs. D. Crowdis; Vice-Pres., Mrs. J. Jones; Rec. Sec., Mrs. J. K. Ferguson, 10 Kane Place; Treas., Miss H. Fisher, Nurses' Residence, Children's Hospital; Archivist, Mrs. G. Smith. *Committees:* Publicity, Mrs. J. Stonley; News Bulletin, Mrs. J. Cameron; Refreshments, Mrs. M. Hill; Telephone, Mrs. N. Vincent; Visiting, Miss J. Simpson; Ways & Means, Mrs. A. Mosher.

### Halifax Infirmary

Pres., Mrs. M. Gordon; Vice-Pres., Miss M. Flinn; Rec. Sec., Miss B. Parsons; Corr. Sec., Miss C. MacDonald; Treas., Miss S. Mason, 39 Armcrescent West. *Committees:* Ways & Means, Mrs. T. Murphy; Program, Mrs. S. Lynk; Visiting, Miss E. Walsh; Rep. to: Press, Mrs. J. Gow.

### Victoria General Hospital, Halifax

Hon. Pres., Miss P. Gass; Pres., Miss L. Hiltz; Vice-Pres., Miss G. Flick, Mrs. D. Bain; Rec. Sec., Mrs. G. F. MacLeod, Forest Hill Drive, Rockingham; Treas., Mrs. D. Price, 28 Arlington Ave., Fairview; Archivist, Miss M. Ripley. *Additional Exec. Members:* Mrs. V. Gormley, Misses G. Gunn, P. MacIsaac. *Committees:* Entertainment and Program, Miss D. Wallis; Telephone, Mrs. O. Mosher; Visiting, Mmes H. S. T. Williams, T. Neiley.

### Aberdeen Hospital, New Glasgow

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### City Hospital, Sydney

Hon. Member, Miss A. Martin; Pres., Miss C. Lamond; Past Pres., Mrs. K. Kerr; Vice-Pres., Mrs. C. Hillcoat; Sec., Mrs. I. Mader, 678 George St.; Treas., Mrs. M. MacKeen. *Committees:* Advertising, Mrs. E. Percy; Gifts, Miss A. Donovan; Social, Mrs. K. Kerr; Visiting, Mrs. K. Pollett; Ways & Means, Mrs. M. Cossitt.

## ONTARIO

### Belleville General Hospital

Hon. Pres., Miss M. L. Peart; Pres., Mrs. G. Rutherford; Pres., Mrs. D. Howie; Vice-Pres., Mmes D. Taylor, B. McCreary, J. Holway; Sec., Mrs. J. Colden, 8 Reynolds Cres.; Treas., Mrs. E. Portt.

### Brantford General Hospital

Pres., Mrs. D. Cheyne; Vice-Pres., Mmes G. McMillan, Wm. Currie; Sec., Miss D. Allin, Gen. Hosp.; Treas., Miss J. McCutcheon, 12 Ada Ave. *Committees:* Flower, Mrs. R. Gordon, Miss E. Lewis; Gift, Mrs. A. Grierson, Miss T. Kett; Social, Miss M. Terryberry. Reps. to: Press, Miss A. Riddle; Local Council of Women, Mrs. H. Marr; Council of Social Agencies, Mrs. R. Weaver.

### Brockville General Hospital

Hon. Pres., Miss A. L. Shannette; Pres., Mrs. M. White; Pres., Miss E. Hurlburt; Past Pres., Mrs. M. Greene; Vice-Pres., Mmes M. Derry, H. Brown; Sec., Mrs. L. Hogan, 125 Abbott St.; Treas., Mrs. M. Andress; Archivist, Mmes M. Findlay, L. Vandusen. *Additional Exec. Members (Property):* Mmes M. Greene, B. Clarke. *Committees:* Advertising, Mrs. M. Bishop; Bazaar, Mrs. M. Gardiner; Membership, Miss E. Thorpe; Social, Mrs. A. Sine; Telephone, Mrs. M. Bishop; Sick Visiting, Miss V. Kendrick. Rep. to: The Canadian Nurse, Mrs. R. Reynolds.

### Ontario Hospital, Brockville

Hon. Pres., Mrs. E. M. Orr; Pres., Mrs. F. Hamblen; Vice-Pres., Mrs. C. Potter, Miss J. Christy; Corr. Sec., Mrs. J. Gaffney; Treas., Mrs. M.



Companion, 66 William St. *Committees: Membership*, Mmes B. Moulson, A. Jones, Miss C. Vogt; *Social*, Miss B. Snider, Mrs. L. Brownlee, Miss M. Snider; *Welfare*, Miss J. Moulds, Mmes M. Hutton, B. Kirker. *Rep. to: Press*, Mrs. E. Wilkins.

### Public General Hospital, Chatham

Pres., M. G. Brisley; Vice-Pres., Mrs. H. Reid, Miss W. Fair; Rec. Sec., Miss M. Campbell; Corr. Sec., Mrs. G. Pritchard; Asst. Corr. Sec., Mrs. M. E. Williams; Treas., Mrs. C. Case, 35 Pitt St. *Committees: Shopping*, Mmes A. E. Harrison, C. Reid; *Educational*, Mmes H. Galderick, M. Irwin; *Social*, Mmes G. McDade, F. Clark, Misses D. Thomas, I. Kangro; *Credentials*, Mrs. F. Renauf, Misses A. Head, W. Fair, *Councillors*, Misses J. Finney, D. Thomas, M. McNaughton; *Historical Research*, Miss L. Hastings; *Rep. to: Press*, Mrs. W. Murphy, *Asst. Mrs. G. Peters*; *The Cdn. Nurse*, Mrs. L. Judd, 4 McKinnon Dr.

### St. Joseph's Hospital, Chatham

Hon. Pres., Sr. M. Consolata; Hon. Vice-Pres., Sr. M. Eunice; Pres., Miss C. Roth; Vice-Pres., Misses D. Marini, S. Charlebois; Corr. Sec., Miss S. Grant, 380 Victoria Ave.; Asst. Corr. Sec., Miss E. Stokes; Rec. Sec., Miss A. Dalton; Treas., Miss M. Grant. *Committees: Program*, Mmes C. Salmon, M. Jenner, Miss M. Ditty; *Lunch*, Mmes S. Sass, P. Zimmer, R. Marshall. *Councillors*, Mmes H. Peco, E. Martin, J. Liddy, Miss L. Pettypiece; *Buying*, Mmes D. Fox, P. Sullivan; *The Cdn. Nurse*, Mrs. C. Jackson.

### Cornwall General Hospital

Hon. Members, Mrs. Baldick, Miss M. Nephew; Pres. Mrs. L. MacLennan; Vice-Pres., Mrs. E. Hart; Sec., Mrs. P. Rutley; Treas., Mrs. Whitney. *Committees: Membership*, Mrs. J. Kilgour; *Flowers & Gift*, Miss E. Allen; *Social & Program*, Mrs. M. McGowan; *Reps. to Press*, Miss L. Baxter; *The Cdn. Nurse*, Mrs. C. (Edwards) Matheson, 224A Pitt, Apt. 5.

### Hôtel Dieu Hospital, Cornwall

Pres., Mrs. S. Hazen; Vice-Pres., Mrs. P. Beard; Sec., Mrs. P. O'Brien; Treas., Mrs. J. Lontaine. *Hôtel Dieu Hosp. Committee: Social*, Mrs. L. Mayhan.

### McKellar Hospital, Fort William

Hon. Pres., Miss G. Johnson; Pres., Mrs. A. Salini; Past Pres., Mrs. F. Standfield; Vice-Pres., Mmes I. Nyberg, D. Poulter; Rec. Sec., Mrs. E. Auld; Corr. Sec., Mrs. V. McKinnon, 915 Brown St.; Treas., Mrs. P. Jarrett, 744 Ernestine Ave. *Councillors*: Mmes C. Crisp, I. Hazelton, G. MacLeod, L. Seed, S. Warren. *Life Member*, Miss J. Hogarth.

### Guelph General Hospital

Hon. Pres., Miss R. Gaw; Pres., Miss M. Featherstone; Past Pres., Mrs. C. Gausden; Vice-Pres., Miss B. Ingles, Mrs. R. Reid; Rec. Sec., Mrs. D. Shaw; Corr. Sec., Mrs. G. M. Elliott, 50 Stuart St.; Treas., Miss C. Ziegler, 48 Delhi St. *Committees: Social*, Mrs. C. E. Matthews; *Program*, Mrs. K. Wright; *Cards*, Miss M. McFee; *Wedding Gifts*, Misses I. Campbell, J. Cox; *Press & The Cdn. Nurse*, Mrs. G. Elliott. *Conv. of Bursary & Scholarship Fund*, Miss L. Ferguson, 42 Delhi St.

### St. Joseph's Hospital, Guelph

Hon. Pres., Sr. M. Audrey; Hon. Vice-Pres., Sr. M. St. Edmund; Pres., Miss R. Carere; Vice-Pres., Miss D. Kraemer; Sec., Miss R. Wilhelm, 9 Cavell Ave.; Treas., Miss T. O'Grady. *Committees: Sick*, Mrs. Newcombe, *Social*, Mrs. Evans, Miss E. O'Grady.

### Hamilton General Hospital

Hon. Pres., Miss M. Hudson; Pres., Miss M. Morgan; Past Pres., Miss A. Thomson; Vice-Pres., Mrs. M. Moulton, Miss S. Shearsmith; Rec. Sec., Miss R. Bowslaugh; Corr. Sec., Mrs. F. Duxbury, 262 Cope St.; Asst. Rec. Sec., Miss J. Zorony; Treas., Miss W. Pinkey, Hamilton Gen. Hosp.; Asst. Treas., Miss D. Rumball; *Archivist*, Miss E. Gayfer. *Committees: Educational Fund*, Walter F. Langrill; *Bursary*, Miss M. Watson; *Flowers*, Mrs. E. Kroch; *Membership*, Miss R. Truscott; *News Bulletin*, Miss P. Humphries; *Program*, Mrs. J. Bryce; *Public Relations*, Miss P. Humphries; *Mutual Benefit Assoc.*, Miss M. Mitchell; *Social*, Mrs. J. Bryce. *Reps. to Local Council of Women*, Mrs. J. Bristow; *Press*, Miss P. Humphries; *Provincial Assoc.*, Miss C. Leleu; *The Canadian Nurse*, Miss P. Humphries.

### Ontario Hospital, Hamilton

Hon. Pres., Miss K. E. Turney; Pres., Mrs. A. A. Kroeker; Vice-Pres., Mrs. M. Sutherland; Sec., Mrs. M. A. McNamara; Treas., Miss E. Orr, O.H. *Committees: Social*, Miss L. Angle, Mrs. A. Smith; *Sick*, Mrs. M. Sutherland.

### St. Joseph's Hospital, Hamilton

Hon. Pres., Sr. M. Grace; Hon. Vice-Pres., Sr. M. Bonaventure; Pres., Miss A. McPhail, 11 Head St.; Vice-Pres., Misses D. Battersby, V. Jennings; Rec. Sec., Miss V. Emery; Corr. Sec., Mrs. M. York; Treas., Mrs. W. Rankin. *Advisory Board*, Misses M. Donavan, E. Quinn, Mmes D. Markle, L. Hudecki. *Reps. to: R.N.A.O.*, Miss D. Richardson; *The Cdn. Nurse*, Mrs. M. Langballe.

### Kingston General Hospital

Hon. Pres., Miss L. Acton; Pres., Miss S. Finlay; Vice-Pres., Miss M. Fitzsimmons, Mrs. A. Tordoff; Sec., Miss D. McLaren, K.G.H.; Treas., Mrs. G. S. Bird, K.G.H. *Committees: Phone*, Miss H. Lake; *Flower & Gift*, Mrs. S. Smith; *Social*, Miss G. Cook; *Private Nursing*, Miss O. Cummings; *Film Council*, Mrs. V. O'Gorman. *Reps. to: L.C.W.*, Mrs. G. Hendry; *Press*, Mrs. W. McKnight; *The Cdn. Nurse*, Mrs. D. Binhammer.

### Kitchener-Waterloo Hospital, Kitchener

Hon. Pres., Miss R. Beamish, Pres., Mrs. H. Schmalz; Vice-Pres., Mrs. H. Hallman; Sec., Miss S. Bauman; Corr. Sec., Miss H. Dinger; Treas., Miss R. Frim, 112 St. George St.

### St. Mary's Hospital, Kitchener

Hon. Pres., Sr. M. Clotide; Hon. Vice-Pres., Sr. M. Paula; Pres., Miss I. Novak, 208 Spring Valley Rd.; Past Pres., Mrs. D. Kehn; Vice-Pres., Miss J. Lippert; Rec. Sec., Miss R. Monaghan; Corr. Sec., Mrs. W. Weber, Treas., Miss P. MacKay. *Councillors*, Mmes A. H. Schmidt, C. P. Sehl, A. J. Hahn, Misses H. Stumpf, G. Zettel. *Committees: Bursary*, Miss P. MacKay; *Entertainment*, Miss M. Cousineau; *Library*, Mrs. T. Dietrich; *Gifts*, Miss C. Bauman; *Refreshments*, Miss M. J. Gamble; *Ways & Means*, Mrs. D. Kehn. *Rep. to: The Canadian Nurse and Press*, Miss J. Voll.

### Ontario Hospital, London

Hon. Pres., Miss Kerr; Pres., Mrs. H. Hilgert; Vice-Pres., Mrs. C. F. Deeley, Miss E. Padgham; Sec., Mrs. I. South, 767 Strand St.; Treas., Mrs. Wm. Soutar, 682 Oxford St.; Asst. Treas., Mrs. F. Cline. *Committees: Social*, Mrs. H. Bruner; *Flower*, Mrs. S. Grosvenor; *Press*, Mrs. W. Wright.

### St. Joseph's Hospital, London

Hon. Pres., Sr. M. Imelda; Hon. Vice-Pres., Sr. M. St. Elizabeth; Pres., Miss A. Riff; Vice-Pres., Mrs. H. Granger, Miss W. Raynard; Rec. Sec., Miss M. Yuhas, 245 Pall Mall St.; Corr. Sec., Mrs. J. Seabrook, 206 Taylor St.; Treas., Miss Creighton, 825 Colborne St. *Committees: Finance*, Miss S. Gignac, Mrs. M. Woods; *Gifts*, Misses V. O'Leary, E. Gervais; *Membership*, Misses E. Beger, I. McTavish; *News Bulletin*, Mrs. M. Harding; *Social*, Misses M. Bogie, P. Pietersma.

### Victoria Hospital, London

Hon. Pres., Miss E. Robson; Pres., Mrs. E. C. Logan; Vice-Pres., Mrs. A. P. Gibberd; Rec. Sec., Miss H. Bell, 43 Victor St.; Corr. Sec., Mrs. M. C. Wake; Treas., Mrs. D. P. Airey, 105 Windsor Crescent. *Reps. to: Press*, Mrs. A. T. Scanlon; *News Bulletin*, Mrs. E. H. McCulloch.

### Greater Niagara General Hospital, Niagara Falls

Pres., Mrs. E. Jenkins, 2099 Carlton Ave.; Vice-Pres., Miss P. Hobson, 665 Simcoe St.; Sec., Mrs. N. V. Scott, 2304 Maranda St.; Treas., Mrs. D. Bredin, 2707 Barker St.

### Soldiers' Memorial Hospital, Orillia

Pres., Mrs. W. Hoult; Vice-Pres., Mmes D. Devine, D. Skinner; Sec., Mrs. Wm. Seymour; Asst. Sec., Mrs. R. Colton; Treas., Miss G. Went. *Auditors*, Mrs. J. Severell, Miss L. V. McKenzie; *Board of Directors*, Mmes G. Wissler, R. Middleton.

### Oshawa General Hospital

Hon. Pres., Miss M. Bourne; Pres., Mrs. B. Mason; Past Pres., Mrs. T. Murphy; Vice-Pres., Miss D. Moore, Mrs. J. Brinning; Rec. Sec., Mrs. G. Baker; Corr. Sec., Mrs. J. Jeffrey; Asst. Corr. Sec., Mrs. D. Agnew; Treas., Miss L. McKnight, 73 Elgin St. W.; Asst. Treas., Mrs. B. Affleck.



**Committees:** Program, Mmes J. Simmons, R. Eakins; Social, Mmes T. Murphy, V. Baker; Remembrance, Miss M. Brown; Rep. to: *The Cdn. Nurse*, Miss E. Wray.

#### Lady Stanley Institute (Incorporated 1918) Ottawa

Hon. Pres., Mrs. W. Lyman; Hon. Vice-Pres., Mmes M. Stewart, E. Young; Pres., Mrs. G. O. Skuce; Vice-Pres., Mmes J. A. Steele, C. H. Port; Sec., Mrs. J. R. K. Main, 464 Wellesley Ave.; Treas., Miss M. Scott, 53 Arthur St. **Committees:** Mmes M. E. Jones, J. A. Steele, L. R. Gisborne, Miss K. Pridmore; *Cancer Dressings*, Mrs. J. Waddell; *Flowers*, Miss D. Booth; *Hospital Visiting*, Miss J. McEwan, Mrs. N. Halkett; *Save the Children Fund*, Miss K. Pridmore. Reps. to: *Local Council of Women*, Mrs. M. E. Jones; *Press*, Mrs. G. C. Bennett; *The Canadian Nurse*, Miss E. Johnston; *Book of Remembrance*, Mrs. C. H. Port.

#### Ottawa Civic Hospital

Hon. Pres., Miss E. Young; Pres., Miss J. Milligan; Past Pres., Miss D. Ainger; Vice-Pres., Mises L. Moke, A. Morrow; Rec. Sec., Mrs. A. Atherton; Corr. Sec., Mrs. S. McPhail, 67 Gilmour St.; Treas., Mrs. A. Gray, 174 Faraday Ave. **Committees:** "Spokes Speak," Miss M. B. Lamb; *Flower*, Mrs. A. Allison. **Councillors**, Mmes E. True, V. Heney, J. Argue, H. Evans, F. Zoppi, Miss E. Webber.

#### Ottawa General Hospital

Pres., Mrs. P. Lamoureux; Vice-Pres., Miss D. McVeigh, Mrs. J. Dunn; Sec., Miss P. Conway; Treas., Miss J. Couture, 270 Bayswater St.

#### St. Luke's Hospital, Ottawa

Hon. Pres., Miss E. Maxwell, O.B.E.; Pres., Miss G. Woods; Past Pres., Mrs. R. Gamble; Vice-Pres., Mrs. J. Dinning; Sec., Mrs. C. Routh, 549 Bay St.; Treas., Mrs. J. C. MacFarlane, 127 Gloucester St. **Committees:** *Flowers*, Mrs. W. Creighton; *Registry*, Miss I. Johnston. Reps. to: *Local Council of Women*, Miss G. Woods; *Press*, Mrs. J. Powers; *The Canadian Nurse*, Miss I. Johnston.

#### Owen Sound General and Marine Hospital

Hon. Pres., Mises E. Webster, W. Cooke; Pres., Mrs. D. McKerroll; Vice-Pres., Mrs. W. McKee; Sec., Miss E. Cook, 110-10th St. W.; Treas., Mrs. D. Watson, 764-3rd Ave. E. **Committees:** *Ways & Means*, Mrs. J. Dewar; *Social*, Mrs. A. Story; *Program*, Mrs. M. Keeling; *Membership*, Mrs. G. Gillesby; *Auditor*, Mr. A. Story. Reps. to: R.N.A.O., Mrs. McKerroll; *Local Council of Women*, Mmes McKerroll, McKee; *The Cdn. Nurse & Press*, Miss Cook.

#### Pembroke General Hospital Lorrain School of Nursing

Hon. Pres., Sr. St. Elizabeth; Pres., Mrs. E. Cully; Vice-Pres., Mmes L. Tario, G. Bryson; Sec.-Treas., Miss B. Cully, Lorrain School of Nursing. **Committees:** *Social*, Miss P. Howard; *Membership*, Mrs. S. Hammond; *Publicity*, Mrs. H. Patterson. **Councillors**, Mmes H. Patterson, G. Hennessy, A. Collins, J. Charette; *Ed. News Bulletin*, Miss J. Bradley.

#### Peterborough Civic Hospital

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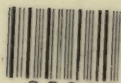
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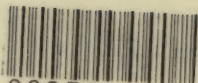
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